PHD

Homicidal bereavement in the UK: listening to and understanding stories from those bereaved through murder and manslaughter
(Alternative Format Thesis)

Alves-Costa, Filipa

Award date:
2018

Awarding institution:
University of Bath

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Homicidal bereavement in the UK: listening to and understanding stories from those bereaved through murder and manslaughter

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A thesis submitted for the degree of Doctor of Philosophy

University of Bath

Department of Psychology

October 2017

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Signed on behalf of the Doctoral College

The material presented here for examination for the award of a higher degree by Research has not been incorporated into a submission for another degree.

Abstract

This research explores homicidal bereavement experiences, particularly for individuals with longer-term difficulties after their loss, and evaluates the impact of a residential, psychoeducational intervention offered by a national charity, Escaping Victimhood (EV). To achieve those goals, a longitudinal mixed method design was implemented prospectively with participants as they attended an EV intervention and retrospectively with those who had attended 2-5 years before.

The literature review (Chapter 1) demonstrates that violent losses (homicide) tend to have greater impacts on individuals' lives (e.g., psychological, financial and social difficulties), compared with non-violent deaths, given the particular characteristics of the homicide itself and aftermath post-event. Furthermore, this review highlighted a lack of evidence-based research investigating what psychological interventions have been evaluated. This led to the systematic review (Chapter 2) to evaluate which interventions are most available, as well as how EV elements compared with those interventions.

This is followed by three empirical chapters (chapters 3-5). Chapter 3 (qualitative study) explores the individuals' perceptions about the post-homicide reality, impacts and experiences of support. Chapter 4, a longitudinal study estimates patterns of psychological difficulties, coping and resilience over time and post-EV intervention. Finally, Chapter 5 qualitatively explored how 29 EV participants (14 were interviewed 6-9 months and 15 at 2-5 years post-EV intervention) progressed over time and what changes, barriers to recovery and future hopes they report.

The overall discussion (Chapter 6) considers the findings of the two reviews and empirical studies performed where the findings from the outlined independent studies are embedded in three main areas, namely: 1) Post-homicide reality; 2) Psychological difficulties & coping and resilience patterns; and 3) Interventions and support needs. Finally, limitations, recommendations for EV, clinical practice, policy and future research directions are included.

To my father Carlos Alberto Costa,

who told me I could accomplish anything I set my mind to with hard-work, dedication, determination and humility.

To my 'mothers' Maria Moreira, Manuela Alves, Ana Costa and Vânia Costa,

who have lived every single step of this PhD journey with me.

And to *all the individuals who faced traumatic and adverse experiences in their lives*, and especially those who have been through an experience of homicidal bereavement.

Acknowledgements

…and because I believe that success is co-constructed…

I would like to begin by thanking Escaping Victimhood and the University of Bath Graduate Studentship Allowance for funding this research through a PhD studentship.

I would also extend my sincere thanks to my exceptional supervisory team, Dr Catherine Hamilton-Giachritsis and Dr Sarah Halligan for their incredible support, engagement, expertise, time and guidance since day one. Thank you very much for all the discussions, feedback and your critical attitude - this has definitely shaped me as a researcher, teacher and person. Catherine, thank you for having believed in my capacity to adjust and improve and all the support you have given me. Sarah, thank you for making me understand that work–life balance is, in fact, a skill that we (junior professionals) need to learn and put in to practice.

I am enormously grateful to all the individuals who took part in this research. Thank you very much for having shared your unique stories with me, and I hope that through this research your voices will be heard. Thank you for making me be a better person, as well.

I also would like to thank the University of Bath and all the staff members of the Department of Psychology, it has been a privilege to work with such an exceptional and talented team. Special thanks to Cynthia Maher, Caroline Ransford, Dr Maria Nikolaidou and Dr Susanna Martin for all their help and kindness; and to Ian Fairholm for having made me understand that it is actually possible to *fake it until you become it*[1] with regards to the adventure of starting teaching. I would like to also thank the members of the Forensic Developmental Psychopathology Group for the exceptional opportunities to listen to very valuable "home-made" research and for their insights on this research also. Furthermore, thank you very much to the members of the Centre for Death & Society for

[1] Amy Cuddy TED Talk - Fake it Till You Make it (https://www.youtube.com/watch?v=RVmMeMcGc0Y).

the shared academic interests and the chance to discuss matters on death and dying. I would like to thank the Media Services for their exceptional help sharing this research. Thank you also to all my PhD colleagues (*gang*) whim whom this last three years were made richer and more enjoyable and to Andrea, Beth and Theo for their generous assistance with data entry.

I am also very grateful to Barbara Tudor, Clifford Grimason and Debra Clothier for all of their support recruiting individuals for this research, as well as for the unique opportunity to learn with them how *"it works in real life – outside academia".* Thank you for all the pivotal work you do to help those bereaved through homicide, for which I hope this research will prove to be helpful; and to Professor Anthony Beech for his inspiring thoughts and to Sarah Ireland for her support, clinical supervision and for making me more *aware* of my strengths and weaknesses.

I would also like to thank my examiners who have kindly agreed to review this research.

…and I am indebted to *many* individuals (because "*home is where the heart is*") without whom this PhD journey would have been a lot less remarkable.

Firstly, I would like to thank my family for all their pivotal support, love, care, understanding and patience. Special thanks are owed to my grandmother (Miquinhas), mother (Nu), sisters (Nani and Babi), nieces (Bia and Carol), and brothers (in law - Tó and Francisco). Bia, o livrinho da Pi (Filipa's little book – translated from Portuguese) is now finished [hurrah!]. Thank you also to my best friend/sister Renata for all her support, love and care since kindergarten. Thank you all for EVERYTHING!

Secondly, I would like to thank *all* my [Portuguese] friends for life (a gente da minha terra) for being 'here and now' with me. Special thanks go to Ana, André, Andreia, Arieiro, Carla, Célia, Cidália, Dianinha, Edgar, Gabriela, José, Julia, Lucas, Mara, Mário, Martano, Miguel, Olga, Pedro, Raquel, Renata, Sara, Susana, Teresa and Virgilio.

Finally, I would like to thank all my *newer* friends (my international family) for the fortunate opportunity to have met them, special thanks go to Alaa, Andréia, Bhagy, Bruna, Chiara, Claire, Daniella, Elaine, Emma, Esther, Evie, Gemma, Gus, Hope, Josie, Juliane, Karlijn, Katy, Lailah, Laura, Mariana, Mary, Meike, Niall, Penny, Renske, Richard, Sara and Theo. I just know we will be friends for life.

Thank you!

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Conflict of Interest Statement

This PhD is co-funded by the national charity, Escaping Victimhood, which aims to help individuals overcome grief as a result of murder or manslaughter across the United Kingdom (UK). However, the research team work independently to the Charity and maintain their academic and scientific rigor, following standardized ethical principles and are as objective as possible. The Charity also sees the need for the research to remain independent and able to report all outcomes, all of which (positive or negative) can help their programme develop.

Introduction

Bereavement is considered a universal experience that most individuals will go through. For that reason, researchers and other professionals have been interested in understanding how individuals function post-loss since the early 1930s when the first studies on the matters of death and dying were conducted (e.g., Eliot, 1933; Freud, 1972; Kübler-Ross, 1970).

Most theories of classic bereavement are based on the idea that *going through* a period of adaptation will be the reality after an experience of losing a loved one (Sanders, 1999). Historically, it is assumed that the expression of intense distress following the death of a loved one is a normative behaviour, especially in western cultures and societies. Thus, the literature suggests that the vast majority of individuals tend to respond resiliently to the loss, showing adaptation and healthy levels of functioning in the first 12 months post-loss, with this being unlikely to dramatically change their patterns of coping and social interactions (Bonanno, 2004; Prigerson, 2004).

Nevertheless, 10% of the bereaved population demonstrate ongoing grief responses for a long period of time and will require professional support (Shear et al., 2011). In fact, the experience of losing someone might constitute one of the most prevalent, distressing and challenging experiences one may encounter across the lifespan (Shear, 2015). Among children and adolescents, similar results were demonstrated (e.g., Kaplow & Layne, 2014; Layne, Kaplow, Oosterhoff, Hill, & Pynoos, in press; Salloum, 2008; Salloum, Avery, & McClain, 2001).

In the last few decades, academic interest among violent/traumatic[2] experiences of bereavement has increased, due to the perceived particular characteristics and queries as to whether these have different outcomes for individuals. For example, homicide (defined as

[2] Suicide and accident can also constitute examples of violent deaths.

murder or manslaughter), which, despite its lower prevalence[3] compared with other forms of victimisation (e.g., domestic violence), usually leaves multiple individuals (family and friends) behind at risk of maladjustment post-experience. Hence it is crucial to understand the individuals' response post-homicide and over time.

Homicidal bereavement

Regarding the characteristics of a bereavement by homicide, some elements appear to contribute to a different path of grief, when compared with other losses. Homicides are usually unexpected, sudden, deliberate and violent in nature, which may distinguish it from non-violent bereavement experiences. It is important to note that non-violent deaths (e.g., due to terminal illness, suicide, accidental death) might also share some of those characteristics, but are less likely to involve other factors, such as criminal trials, lack of information (e.g., missing body), hearing too much information (e.g., at criminal trials), perpetrator's sentencing and media reporting (Beard & Kashka, 1999; Malone, 2007).

Some studies have found that homicidally bereaved individuals reported greater psychopathology (e.g., Post-Traumatic Stress Disorder [PTSD], depression and Complicated Grief [CG]) than individuals bereaved by suicide or accidents, for instance (e.g., van Denderen, de Keijser, de Huisman, & Boelen, 2016; Zinzow, Rheingold, Byczkiewicz, Saunders, & Kilpatrick, 2011; Zinzow, Rheingold, Hawkins, Saunders, & Kilpatrick, 2009). In addition, individuals often report physical and somatic reactions, as well as financial issues and difficulties with social relationships (e.g., isolation; e.g., Malone, 2009), as well as changed worldviews (e.g., Mancini & Bonanno, 2011).

In summary, there is growing, valuable research on homicidal bereavement, including immediate outcome and unique aspects. However, less is known about the individuals' ongoing psychological difficulties as the time goes by, as well as (perhaps

[3] It is estimated that 262,772 people were killed in 2015 by homicide (United Nations Office on Drugs and Crime [UNODC] 2017). On the other hand, it was estimated that 1.3 million female and 716,000 male were victims of domestic abuse in 2016 (Crime Survey for England and Wales [CSEW], 2017).

ongoing) needs. Therefore, one key aim of this thesis was to investigate perspectives of change, both from the participants' point of view and over time.

Finally, in terms of psychological interventions to support homicidally bereaved individuals, it is of interest to consider whether individuals have the same or different needs to those of individuals following 'normal' bereavement.

Interventions following homicidal bereavement

Regarding national services in the UK, Victim Support offers immediate support for victims of crime including individuals bereaved by homicide. This independent charity provides a Homicide Service that aims at informing individuals about the criminal justice system, as well as offering help within a variety of areas, such as, emotional support, funeral arrangements and financial assistance. Furthermore, their case workers can also refer individuals to specialised services (e.g., trauma and bereavement therapy/counselling, restorative justice, peer support).

Alongside nationally available support, other opportunities can be provided by charities, such as Support After Murder and Manslaughter (SAMM) and Escaping Victimhood (EV). These organisations arose to fill the perceived ongoing maladjustment of those bereaved by homicide beyond that available from Victim Support. Their group support offer additional help and information (e.g., legal and coping strategies).

The Escaping Victimhood charity and programme

Founded in 2005, Escaping Victimhood **(**EV) is a national charity that offers[4] a four-day residential, experiential group intervention (Appendix A)[5] across the United Kingdom (UK) for those affected by serious crime, including homicide. These interventions are funded by different organisations covering the costs associated with the intervention (i.e., accommodation, subsistence, travel expenses, meeting rooms and

4 More information about the EV programme can be find on their website: http://www.escapingvictimhood.com/.

5 EV intervention/programme, EV residential intervention/programme and residential workshops will be used as synonyms in this thesis.

facilitators). Individuals can be referred by a practitioner (e.g., medical practitioner, Victims Support services) or self-refer, and usually attend following any legal process. In addition to the residential workshops, a one-day (non-residential) follow-up is held six to eight weeks after each residential workshop[6]. It should be noted that individuals referred into an EV programme have usually received significant input from other services (including Victim Support), but continue to have significant ongoing difficulties.

However, despite anecdotal evidence of change, the EV programme has not been well-evaluated to date. Despite the very positive feedback provided by the individuals at the end of the workshops and follow-up day, it is unclear whether the programme is effectively helping individuals to better cope with their experiences, as well as whether improvements would be maintained or not over time.

Other professionals/services, such as Victims Support and Homicide Support, usually refer individuals to attend the EV intervention. Therefore, it should be noted that individuals referred have usually received significant input from other services, but continue to have significant ongoing difficulties to adjust following the homicide. In fact, and as it was demonstrated in the quantitative study (chapter 4), participants reported severe psychological difficulties. For example, trauma, depression and anxiety scores reached clinical significance. The qualitative elements (chapters 3 and 5) of this research have also corroborated those findings, as individuals described themselves as changed by the homicide and reported ongoing psychological difficulties. It is important to note this research has not objectively measured the type and amount of support previously received and that this could be included in future studies.

Aims and rationale

Therefore, considering the issues outlined above, this thesis aimed to gain a better understanding of homicidal bereavement for those individuals known to have longer-term

6 The one-day follow-up aimed to listen to individual's perceptions about the EV programme. Therefore, data was not collected, in order to avoid possible bias.

difficulties and to evaluate the impact of a residential, psychoeducational intervention (namely, that of Escaping Victimhood). Specifically, the following thesis aims were generated:

1. To gain an understanding of the impacts of homicidal bereavement, including psychological impact, coping responses, and potential moderators of impact (e.g., time since loss, relationship with the victim/offender) and evaluate whether this differs to 'normal' bereavement (Chapters 1, 3, 4 and 5).
2. To systematically evaluate the current literature on the main psychological interventions available for homicidally bereaved individuals (including how the EV programme fits within what is known) and to review the effectiveness (Chapter 2).
3. To gain an in-depth understanding of how *individuals* perceive their experience post-homicide, particularly in terms of change, perceived support and coping strategies (both immediately and over time; Chapters 3 and 5).
4. To evaluate psychological difficulties, coping and resilience patterns of individuals attending the EV programme, pre and post intervention, but also over time (four to six weeks and six to nine months post-intervention; Chapter 4).
5. To consider any patterns that might be found between level of psychological difficulties and other factors, such as socio-demographic, victim and perpetrator relationship (Chapter 4).
6. To evaluate participant perspectives about the impact of the EV programme, including potential benefits and areas for development (Chapters 3 and 5).

To achieve these aims, this thesis adopted a mixed method approach, with both prospective and retrospective elements. Participants were recruited from Escaping Victimhood programmes (prospectively in 2014 to 2017) and retrospectively (attended a

programme 2-5 years before). Significant efforts were made to recruit a control group (e.g., community sample, waiting list control) but this was not possible. This methodology will be outlined in more detail below.

Epistemological approach: rationale

Mixed-methods approaches are described as powerful, partly due to its flexibility (Tashakkori & Creswell, 2007). Indeed, by combining quantitative and qualitative elements, a mixed-methods design is likely to offer an in-depth understanding of the phenomena and social reality of our participants (e.g., Denscombe, 2008; Sale & Brazil, 2002). In particular, the current research adopted a fixed *Embedded Design* (Morse, 1991, 2003), hence two different, independent strands (quantitative and qualitative studies, respectively) were collected and treated separately. Findings were merged and integrated, which provided a holistic understanding about homicidal bereavement experiences.

Regarding philosophical paradigms for the mixed-methods approaches, pragmatism is generally the most followed, as it attempts to provide a distinction between what is considered purely quantitative (based on a philosophy of (post-)positivism) and purely qualitative (based on a philosophy of interpretivism or constructivism; Johnson & Onwuegbuzie, 2004; Maxcy, 2003; Rallis & Rossman, 2003). Thus, pragmatism offers the chance to bridge dichotomies likely to exist in mixed methods approaches to social sciences, rather than offering limited views by trying to address the 'only truth' regarding the phenomenon under study (Biesta 2010). Instead, pragmatic researchers seek to incorporate the possible truths about and focus on the implications of the research by including objective measurable dimensions, as well as providing meaning-making to the individuals' experiences (Morgan, 2007).

For this research, and in contrast with the more 'rigid' paradigms, pragmatism informed our outcome-orientated approach. In fact, and as demonstrated before (Biesta, 2010; Johnson & Onwuegbuzie, 2006), the research team's approach sought to inform policy and practice by communicating and sharing the individuals' voices about their own

experiences post-homicide. Pragmatism, as our epistemological approach, has also reflected our belief about the potential "transferability" of knowledge to other similar circumstances. However, the research team would describe themselves as capable to keep objectively both in our reflections on research and in data collection and analysis.

More specifically, the epistemological paradigm followed informed the overall theoretical framework used, the research design, data collection, and the interpretation/discussion of the research conclusions. In fact, the research team has intentionally explored the status of the literature regarding homicidal bereavement experiences before and after data collection, as it is seen to be the most effective strategy to connect theory and data when pragmatism is followed. Furthermore, pragmatism informed the methodological design of the overall research project. It was established that quantitative and qualitative data would be collected to provide a more comprehensive understanding of experiences of homicidal bereavement that would otherwise not have been accessible by using only one approach alone (Creswell & Clark, 2011).

Our purpose for following a pragmatism paradigm was to determine and communicate practical solutions to increase knowledge about those bereaved by homicide, as well as improve understanding about how society and health services could help individuals to adjust and cope with such potentially traumatic experiences. However, it is important to note that objectivity in data collection was taken in consideration at all stages of this research process. In fact, the individuals' psychological difficulties were measured by using validated questionnaires. Furthermore, the same interview guides were used to conduct the interviews with all of the participants. Finally, the research team invited independent researchers to provide feedback about both quantitative and qualitative analyses that were preformed in order to ensure academic rigor. Nevertheless, as pragmatic researchers, we allowed the possibility for subjectivity, by considering the diverse perceptions and views of our participants and by giving them a voice about their post-homicide reality, as well as perception about the EV intervention.

In summary, the epistemological paradigm followed in this research provided adequate and in-depth understanding about homicidally bereaved individuals, where qualitative and quantitative data complemented each other. This was clearly noticeable when both strands of data where embedded (see Discussion of the thesis) and mirrored with research conducted previously. In fact, the pragmatism paradigm followed was flexible enough to capture objective and subjective perceptions.

Recruitment of participants

Participants were recruited from eight residential intervention groups run by EV between September 2014 and October 2016 (selection for the EV residential programme itself was done by the EV team). Individuals were invited to take part in this study on day one of the programme they attended (Appendix B, C and D). Therefore, a convenience sampling method was used. Participants were given information about the longitudinal nature of the study, as well as the qualitative and quantitative elements that this research incorporates. Furthermore, half of the participants who took part in the EV intervention two to five years ago were invited to take part in the longitudinal qualitative study via the EV team (Appendix E; full details are available in Chapter 5).

Participants were allocated to attend the EV intervention, the EV director sent a letter with general information about the EV programme, which also included a brief summary about the research and its voluntary nature.

When participants arrived at the venues (day one) and during the welcoming section, Filipa Alves-Costa offered detailed information about the nature of the studies (quantitative and qualitative), the importance of exploring their experiences, clarified key ethical considerations (e.g., voluntary and confidential nature of the research), and invited them to participate. Furthermore, participant information forms were given to all of the participants and if they agreed to participate consent forms were then signed. It is important to note that for the follow-ups assessments and following the individual's consent, Filipa contacted them directly.

Finally, the EV director also posted an invitation letter to participants who participated in previous editions of the EV intervention to invite them to participate in our longitudinal qualitative study (chapter 5), providing the research teams' contact details in case they would like to take part.

Filipa Alves-Costa collected all of the data for this research. Data was collected face-to face during the EV residential intervention, including quantitative measures at pre-intervention (Chapter 4) and a semi-structured qualitative interview (during day two and three of the EV intervention; Chapter 3). In addition, anonymised follow-up questionnaires were posted to the participants six to nine months post-intervention (a cover letter and a pre-paid envelop was included). Finally, the follow-up interviews (six to nine months and two to five years) were conducted and recorded (with the individual's informed consent) by phone (Chapter 5).

Overall, 74 individuals took part in eight groups, of which 68 individuals[7] (91%) agreed to take part in the quantitative element of this research at pre-intervention. It is important to note that the number of participants decreased over time, as is frequently reported in other studies of this nature. Nevertheless, response rates were relatively high (post-intervention: 75%, follow-up I: 54.4%; follow-up II: 48.5%; Chapter 4).

Furthermore, theoretical saturation[8] informed the number of participants included in the qualitative studies. Thus, when theoretical saturation was reached, participants were only informed and invited to take part in the quantitative study. In this sense 21 participants took part in one of the qualitative elements of this research (Chapter 3), and another 29 took part in the other qualitative element (Chapter 5).

In addition, a call for volunteers was launched, as previously mentioned, through the local and national media in the UK (i.e., supported by the media services at the

[7] One participant was excluded from the analyses as he/she dropped-out at the beginning of one of the EV interventions.

[8] Theoretical saturation – when new data did not lead to more/new information related to the research questions (Seale, 1999) – informed sample size, as suggested in the literature (e.g., Braun & Clarke, 2006).

University of Bath and College of Policing). This aimed to establish a comparison between homicidally bereaved individuals who attended to the EV intervention and a community sample. Unfortunately, this strategy was unsuccessful and recruitment in the community discontinued.

Recruitment process: reflective approach

A convenience sampling method was used for this research (as mentioned above), meaning that all of the individuals who took part in the studies attended the EV intervention. This approach was seen as the most appropriate, as one of the core aims of this research project was to evaluate how EV attendees were responding to the psychoeducational intervention. In that sense, the sampling strategy was effective, as it was possible to estimate psychological, coping and resilience patterns of change over time, as well as explore the individuals' experiences of change, consequences and adjustment post-homicide (due to the longitudinal mixed method approach used).

However, the limitation of this sampling is that, despite the novel and significant results of this research project, findings are tentative and not generalizable across other populations. They should therefore be interpreted with caution. Indeed, the research team aimed to include a control group with homicidally bereaved individuals who had not attended an EV intervention (community sample). This would have allowed *more* robust conclusions to be drawn. As noted above, significant efforts were made in order to gain access to potential non-EV participants. A number of steps strategies were undertaken which aimed to advertise the study on a national level. Those strategies included national radio interviews, distribution of leaflets, online advertisement, and contact with core third sector services. An online measurement tool was made available in order for individuals to respond to it directly, or for it to be shared between potentially interested people. All of the participants were offered the possibility of attending an EV intervention at a later point, if they wished to do so. This strategy was revealed to be unsuccessful and the recruitment of a community sample was discontinued due to time limitations. Despite the frustration felt

at the time, this ineffective recruitment strategy can inform the recruitment of participants as part of future research.

Firstly, and as demonstrated in previous research, homicidally bereaved individuals are a vulnerable group with severe and ongoing psychological difficulties. Vulnerable populations are often difficult to recruit into studies (Crosby, Ventura, Finnick, Lohr, & Feldman, 1991) and this might have been a possible cause to the non-engagement of individuals. In fact, individuals might actually feel anxious about the research protocol, fear and distrust of researchers, as described in previous research with vulnerable groups (Sutton, Erlen, Glad, & Siminoff, 2003).

Secondly, when contacting health care providers for instance, who often serve as gatekeepers to potential research participants, a *more* integrative approach than the one taken by the research team is needed in future studies. In fact, it might be important to try face-to-face meetings where the research project can be presented and they could be given the chance to provide their insight about the recruitment strategy/research project. Such meetings could potentially include information about the aims of the research, reasons for the study, ethical guidelines that guide decision making (e.g., methodological design, rights of potential volunteers), intervention aims and outcomes, as well as the evaluative process and the dissemination of the findings (Sutton et al., 2003). This might increase the chances for a greater engagement between research teams and third parties.

In summary, the research strategy to recruit homicidally bereaved individuals used in this project proved to be challenging. This highlighted the need for a careful and timely recruitment plan, especially if research teams do not work/cooperate with potential gatekeepers beforehand.

Research tools and data treatment

***Quantitative approach*.** This research used structured self-administrated validated questionnaires. The measures used were either purchased or given consent to be used by the authors. Furthermore, sociodemographic, medical and crime-related information was

also collected. The quantitative data was analysed using a computerised statistical package (IBM SPSS 22). Multilevel modelling for repeated measures was the most appropriate statistical technique to analyse the data, due to their longitudinal nature (i.e., measuring change across time), as well as its robust nature to address missing data (e.g., Raudenbush & Bryk 2002; Söderfeldt et al., 1997). In fact, multilevel modelling is increasingly popular among social sciences to analyse multiple wave studies, offering more robust alternatives to, for example, ANOVAs. (See **Chapter 4** for detailed information about tools and quantitative methodology).

Qualitative approach. Semi-structured interviews (Appendices F and G) were developed for the two qualitative studies conducted. Participants were asked to discuss their interpretations and perceptions about their post-homicide experiences (e.g., consequences, coping strategies and experiences of support), their EV experience, as well as recommendations for future practice.

Interview guides were developed based on a cross-literature search in a variety of areas, including: interventions, emotional/psychological responses/psychopathology, victimisation, homicidal bereavement experiences, stress, and coping management. These were validated by the EV team (experts working in this field for several years) by providing feedback and suggestions in the generation of interview questions. In addition, a pilot group was run in September 2014 and changes to the interview guide were made following participants' feedback and from the researcher's self-reflection on the interview. Thus, two changes were made: 1) five questions were merged, as they shared very similar content (e.g., coping strategies and patterns post-loss), and 2. technical and academic language was substituted by more simplistic terminology (e.g., psychological difficulties or emotional issues instead of psychopathology).

All the interviews were audio-recorded and transcribed verbatim ready for the purpose of coding and in-depth qualitative analysis (Filipa Alves-Costa transcribed 27 of the audio recordings, with a professional transcription service completing the remaining

transcriptions due to time limitations). The duration of the audio recordings varied and lasted between 20 minutes to two hours.

The research employed a qualitative design by using an inductive Thematic Analysis method, "a method for identifying, analysing, and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 79) across a data set. QSR NVivo10 software, a professional software package with the purpose of facilitating the process of qualitative data analysis was used to support the process of conducting the analyses. The process of data analysis itself occurred in different phases/steps, as suggested by Braun and Clarke (2006). Filipa Alves-Costa familiarised herself with the data and became as familiar with it as much as possible. This process occurred by transcribing and listening to the audio recordings, as well as reading the transcripts several times before starting the analysis. In the primary stage, she went through the coding process independently. The coding system was gradually generated, as she was focusing on domains related to this subject (e.g., feeling, perceptions, changes, opinions and suggestions were robustly searched). In a second phase, and in order to insure academic rigour and reliability, independent coders[9] preformed blind coding for ten per cent of the interviews. In a third stage, the research team checked both coding systems and it was decided that the themes 'changed self' and 'changed world' (initially two separate themes) should be merged, due to the overlap between the two. Finally, comparisons between the two coding systems and results from Cohen's K test indicated a high level of agreement between coders and findings were written up.

Ethical considerations

The Psychology Ethics Committee (University of Bath) provided full ethical approval for the project on the 4 of September 2014 (Ref. 14-186; Appendix G).

[9] Different individuals were asked to do the blind coding for the two qualitative studies for the sake of academic rigour.

Furthermore, this research complied with British Psychological Society and Health and Care Professions Council guidelines to insure ethical research.

Individuals were informed about the voluntary nature of their participation and that their choice would not impact on their attendance on the EV programme. They were also given the option to choose to answer some but not all questions, as well as withdraw from the study at any point without any implications for them. Finally, individuals who agreed to take part in this research signed a consent form. At the completion of their involvement debriefing forms were given to all participants (Appendices C, D and F). Due to the longitudinal nature of this study, it was decided to discontinue the contact (e.g., phone calls, email, post) if individuals demonstrated any signs of not wanting to carry on participating in the research.

Regarding the confidentiality of the data, names of individuals were linked to a case number and only Filipa knew which number related to which individual. The list of names and case numbers were stored in a locked filing cabinet and held in a password protected file. Data storage and retention are, as outlined in the University of Bath's Code of Practice for Research, stored in a locked filing cabinet at the University of Bath. The audio tapes of the interviews were destroyed as soon as the transcriptions were completed. Anonymised transcripts and quantitative raw data will be kept for a minimum of 10 years after completion of the study, as required by the British Psychological Society.

Data entry and analysis took place at the University of Bath and computers were password protected. Only members of the research team (Dr Catherine Hamilton-Giachritsis, Dr Sarah Halligan and Hope Christie) and the research assistants (Andrea Pintos, Beth Mason and Theo Metcalf) had access to the anonymised data.

Regarding the topic of this research, it was anticipated that some participants may feel upset or distressed when reading/listening to some questions, not least because individuals are usually experiencing quite high degrees of emotion on attending these programmes. Thus, a plan of action was developed in case individuals felt overwhelmed

(e.g., normalising their emotional reactions; advising them to see some of the EV trained facilitators during the EV programme; providing information about services where they could seek support if needed when the interviews were contacted by phone). Furthermore, a brief report with the main findings of this research was posted to all of the participants.

In terms of the risks related to the data collection processes, this was expected to be minimal, due to the group nature of the EV intervention (when data was face-to-face collected) and Filipa's previous clinical training. Nevertheless, Filipa engaged with not only academic, but also with clinical supervision (Appendix I).

Practitioner/researcher reflection

Gibbs's reflective approach (six stages of reflection; Gibbs, 1988) was used to guide my practitioner/researcher reflection about the nature of the research conducted and the potential impact this may have on researchers and the research itself.

Description

Very little has been written/communicated about potential difficulties that might arise when researching traumatic topics (e.g., victimisation, perpetration, war, death and dying). Furthermore, and perhaps as a direct consequence of this lack of information, very little attention has been given to doctoral students and/or junior researchers and how both the research process and personal characteristics might directly impact on their emotional and physical wellbeing. Those characteristics relate to the nature of the research itself, the lack of clinical supervision within academia, and the associated absence of previous coping and management training, personal experiences of violence, and trauma or other life events that can arise (before or during the course of the research). Furthermore, relatively little is known about how junior researchers (especially doctoral students who have not undertaken clinical training) respond to and make decisions in practice, and how those decisions may have an impact on either themselves or the research process, or both.

Some studies started to determine how researching sensible or demanding topics might lead to emotional /psychological difficulties both during and/or even after completing the

duties as a researchers for a particular project (Dickson-Swift, James, Kippen, & Liamputtong, 2007; Johnson & Clarke, 2003; Liamputtong & Ezzy, 2005; Woodby, Williams, Wittich, & Burgio, 2011). In fact, and as noted in a very recent paper by Kumar and Cavallaro (2017), qualitative studies conducted in specific contexts appear to be more likely to have a negative impact. These contexts include, although not exclusively: disabilities, bullying, HIV/AIDS, chronic and/or terminal illness, death and dying, intimate partner violence, sexual abuse, suicide and animal abuse (McGourty, Farrants, Pratt, & Cankovic, 2010).

Given that research has demonstrated that researchers can be emotionally and psychologically impacted upon by the topic they are studying, it is actually surprising that training about emotional and psychological well-being/difficulties is not always available (or not as often/structured as it should). For that reason, this section will include a detailed personal reflection about my personal experience as a junior researcher and actions that could become available to support future researchers. Furthermore, a brief summary of this personal refection is included in the final chapter of this thesis.

Feelings

Firstly, it is important to provide some background about my training and professional experience. I have a Degree in Psychology and a Master's Degree in Justice/Forensic Psychology. As an Assistant Psychologist (AP) and on clinical-forensic placements, I learned to use psychological models in individual and group settings, with children and adults in a diverse range of areas (e.g., domestic and sexual abuse, cognitive impairments). With the guidance of supervision, I conducted structured assessments, delivered evidence-based psychological interventions, and ensured that outcome measures were used to monitor progress (at baseline, post-treatment and follow-up). Therefore, it gave me the opportunity to better understand that 'real world' settings can be difficult to deal with and how this is something crucial to make students aware of at an early stage of their academic journeys.

I still recall some of my professors/supervisors narratives describing their challenging experiences as a researchers and clinicians. But, nothing that practice could not teach us about (they used to say). At the time, it all sounded fascinating and what I wanted the most was to gain first-hand experience. However, I do still remember how uncomfortable I felt when I first listened to a five year-old girl's narratives describing what "her dad did to her". I remember leaving that session in tears and thinking that I was not sure if I could see the little girl again for the second assessment. Following this session, I went to see my supervisor and shared how difficult it was to deal with that experience and I asked her for some advice. Some strategies included using supervision effectively and developing insight into and learning how certain things may affect us, given our history and life experience. So that developing this awareness and insight helps out manage certain clients and their life stories better.

Evaluation

…Well I want to believe that practice did not make me thick-skinned nor have I just become used to listen to horrible narratives of suffer and distress. I do believe that by interviewing a variety of vulnerable populations, combined with some of my personal characteristics, I have had the opportunity to increase my levels of resilience to cope with adversity and manage signs of distress in others.

Looking back to when I started my PhD (September 2014), more specifically recalling the first few interviews I did with a homicidally bereaved individuals, I felt sad, shocked and powerless. I was not the therapist anymore. It was not my role to support them, to build up an action plan or to help them cope with their experiences. I was the researcher this time. This was a 'new issue' for me and I had to learn how to cope with it. If before (as an assistant psychologist) I felt uncomfortable listening to violent narratives, this time (as a researcher) I had the difficult task to find and accept my new role. I have to say that it was difficult… very difficult! Furthermore, both my supervisors and I agreed that I would

engage with external clinical supervision, given the potentially traumatic topic I was researching.

The clinical supervision was actually very helpful, as I had the chance to share with someone completely neutral and independent from my doctoral research project/team, how difficult it was for me to listen to some of the stories. Furthermore, I quickly understood that I actually was there to help them. I was listening to their stories, I was genuinely interested to know how they feel/felt (now and then), and I wanted to collect as much evidence as I could to help improve care and services for them. I then understood that I had a mission, I was going to be their voice and that was such a relief for me!

Methodologically and given the residential nature of the EV intervention, some of the data was collected during the EV residential intervention. Following the intervention, where all of us (participants, facilitators and me) were together for four days, I used to feel exhausted, overwhelmed and excited by all the new data gathered. But, some of my journeys home were challenging and I felt the need to find self-care strategies. I adopted a number of strategies such as: allowing myself to be in silence, exercising, trying to sleep more, engaging with clinical supervision, stopping myself to immerse in the collected data straightway, writing diaries/notes (not used in this research) and accepting help to do data entry and transcribing some of the interviews. They have really worked for me.

Analysis

Considering that research has already shown that researchers can be emotionally and psychologically affected and based on this process of self-reflection as a practitioner/researcher during and after completing this research, I consider that some recommendation could be highlighted to help others starting their journeys as junior researchers, as follows.

At a more institutional level, it could be important if students had the chance to build their levels of resilience, as well as be made aware that sometimes researching certain types of areas is challenging and might directly affect their personal lives and

wellbeing (it might not be something obvious for junior researchers to 'see'). Thus, self-care should be seen/taken as an essential component of the research process. Furthermore, it would also be important if junior researchers had the opportunity to engage with clinical supervision (for free). Moreover, it is necessary to break the idea/stigma that researchers do not have feelings and that they do not influence the research process itself – as it actually does! Furthermore, it should be the institution's responsibility to ensure their staff's well-being, and therefore provide the necessary support that is deemed 'normal' in any other organisation that deals with these sensitive issues on a day-to-day basis.

Conclusion & Action plan

Finally, and on a more personal level, what would be important for junior researchers to have is the routine to engage with self-reflection (since day one), as this is likely to make them more aware of their feelings, thoughts, fears and needs as individuals and researchers.

In summary, those 'small' strategies might actually result in more responsible research practices, happier and healthier researchers and individuals, as also noted by Kumar and Cavalharo (2018). Considering my own experience, I was extremely lucky, as I had the chance to clinically train before conducting my doctoral studies, had a supervisor who is a clinician herself, engaged with clinical supervision and had excellent informal support.

Thesis format

The research aims outlined above will be addressed in the different chapters of this thesis. This thesis presents the following structure:

Chapter 1 presents a general literature review that aims to provide some of the bereavement theoretical framework available in the literature, as well as an overview of the current knowledge and understanding of the homicidal bereavement experiences. It summarises definitions, prevalence, impacts post-loss and potential moderator effects.

Chapter 2 consists of a systematic review examining the effectiveness of psychological interventions for homicidally bereaved individuals.

Chapter 3 aimed to qualitatively explore individuals' perceptions of homicidal bereavement, change(s) and experiences of support post-loss among 21 family or friends homicidally bereaved.

Chapter 4 reports on a quantitative longitudinal study intended to estimate prevalence of psychopathology (overall psychopathology[10], PTSD, CG), coping and resilience trends at four time-points (i.e., pre-intervention, post-intervention, four to six months follow-up and six to nine months follow-up; N=68, N= 61; N=37; N=33, respectively) among homicidally bereaved individuals that attended the EV intervention. Furthermore, socio-demographic, time since loss and kinship between the bereaved individuals victim and perpetrator were tested as predictors of the outcomes. This chapter enabled a quantitative evaluation of the effectiveness of the EV programme.

Chapter 5 presents a qualitative longitudinal study of 29 individuals (14 participants were recruited from Escaping Victimhood programmes – prospective element and 15 individuals attended a EV programme 2-5 years before - retrospective element). This study aimed to understand the individual's progression over time in terms of change, barriers to recovery, as well as perception of their overall future. Furthermore, it provided

[10] This was measured using the Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983), which includes nine clinical dimension (i.e., somatisation, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism).

information about which elements of the EV intervention are perceived as beneficial (or not) and how it has contributed to the individuals adjustment over time.

Chapter 6 provides a general discussion of the main research findings presented in the different chapters. This chapter discusses the main limitations of the studies and reflects on clinical and policy implications, as well as provides suggestions for future research directions.

Note: This thesis adopts an alternative format (i.e., it includes manuscripts that have been submitted for review). Therefore, and citing the University of Bath's regulations:

"As each academic paper will have self-contained components that may overlap with other sections of the thesis, there may be some duplication of material. The Guidelines for examiners of candidates for degrees by research at the University of Bath alerts the examiners to expect some duplication." (QA7, page 9).

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Chapter 1

From theoretical frameworks to the particularities of homicidal bereavement experiences: a narrative review

Chapter Rationale

This narrative literature review aimed to reflect on the main bereavement theories, as well as identifying research conducted with homicidally bereaved individuals nationally and internationally. The purpose is to contextualise homicidal bereavement within the wider, general bereavement literature and to consider if they differ (if at all). This answers the research question of what is unique about homicidal bereavement and does it lead to outcomes and/or intervention needs over and above normal bereavement.

Therefore, theories of overall experiences of bereavement are reviewed, as they play an important role in informing understanding the particularities of homicidal bereavement. In addition, this narrative review synthesises existing knowledge with specific reference to experiences of homicidal bereavement.

From theoretical frameworks to the particularities of homicidal bereavement: a narrative review

In order to consider the specificity of homicidal bereavement, it is useful to begin by reviewing theories of general bereavement, before moving on to consider homicidal bereavement. In particular, how it is defined, what is currently known about similarities and differences with general bereavement, and an overview of research on the outcomes.

Bereavement and loss: an overview

Bereavement can be perceived as one of the most prevalent, distressful and challenging experiences across the lifespan (Shear, 2012). In a study conducted in six continents with 68,894 respondents across 24 countries (Benjet et al., 2016), 31% of adults identified the unexpected loss of a loved one as a traumatic event (the causes of deaths were not reported). In defining a new field of knowledge, the 'social psychology of bereavement' was coined in 1933 (Eliot, 1933). Since then, there has been development of numerous psychological models of bereavement that are intended to explain grief processes, such as psychodynamic theory (Freud, 1972), attachment theory (Bowlby, 1961, 1980), and stages and tasks models (Kubler-Ross, 1970).

Despite the increased overall understanding provided by these models, they tend to describe individuals as passive within their grief process, and provide limited information about individual and contextual variations that might impact such experiences. Thus, these classical frameworks do not account for individual differences, causes of death, relationship and quality of the relationship with the deceased, pre-loss health issues, social mediators and concurrent stressors (Stroebe, Schut, & Boerner, 2017). They also focus particularly on emotional reactions to the loss and say little about cognitions (e.g., how individuals process their experiences) and behaviours (e.g., coping strategies), which are also involved in the grieving process. Consequently, to some extent these early models are mainly descriptive and empirical support is limited.

In contrast with *positivist views* (which focus on universal responses post-loss), the *postmodern social constructionist* approaches account for oscillation between avoiding and engaging with their adaptation to the loss, plus acknowledgment of the possibility of resilience and personal growth post-loss (Neimeyer, 1997). Thus, the more traditional focus on emotional outcomes has been expanded to include other dimensions, such as cognitive, social, cultural and spiritual (Hall, 2014).

In summary, classical models of bereavement provided a crucial starting point and indeed contributed to the overall understanding of post-loss experiences. However, they also provided an over-simplistic explanation of grief responses, and thereby may have limited use on clinical practice (Stroebe et al., 2017). Stroebe et al. (2017) suggest the use of more flexible approaches that particularly elucidate physical and mental needs that may require professional intervention (Shear, 2015).

The following section summarises the most popular frameworks currently in use that seem to make the strongest contribution to the overall understanding of homicidal bereavement.

Meaning making models

Models of meaning making, offer a more idiosyncratic process to understand grief responses, where individuals attempt to find *the meaning* of their loss experiences. This process involves: redefining the self and how to engage with the world. Previous research has demonstrated that the meaning making model is seen as an adaptive strategy and suggests that a non-coherent/disorganised narrative of the bereavement experience might impact on how individuals respond to the loss. Failing to find meaning increases the risk of psychopathology, as it seems to involve a constant rumination around the event (Nadeau, 1988; Neimeyer, 1997, 2001).

Four-component model

Individual and contextual variables are likely to impact on how individuals respond to adverse experiences. Thus, the four-component model (Bonnanno & Kaltman, 1999)

was developed to specifically understand individual differences in grieving and how individuals differently respond to loss based on: 1) the context in which the death occurred (e.g., it was expected or unexpected; timely or untimely); 2) the subjective meanings associated with the loss (e.g., loss perceived as unfair); 3) continuing connection with the person who died (e.g., not *letting go*); and 4) the role of coping and emotion regulation (e.g., adaptive vs. non-adoptive strategies). Thus, variations in each of these components of the individual's response are likely to contribute to different (more or less mild or severe) emotional and functional responses to bereavement. This model has influenced the resilience model, as it has highlighted the importance of individual variables.

Resilience model

More recently, Mancini and Bonanno (2006) proposed a continuum-based changeable process where the expression of positive feelings, self/flexible regulation of emotion expression, as well as self-disclosure about the bereavement experience, are crucial components of adaptation. Their research has demonstrated that most individuals show resilience post-bereavement, with overall functioning being maintained despite intense yearning and intrusive thoughts (this is especially true for non-violent forms of deaths). In particular, flexible adaptation and pragmatic coping seem to be more often associated with resilience. Thus, should be considered when designing, developing and implementing psychological interventions.

Stress and coping models

Stress and coping based models were not developed to specifically explain and/or understand post-loss responses. Nonetheless, theoretical orientations based around stress and coping approaches have influenced the field of bereavement in the past two decades. In essence, these approaches suggest that coping styles will impact on how individuals adjust to loss. For example, it is expected that emotion and problem focused strategies impact on different outcomes – with problem focused strategies contributing and promoting to adaptation to the loss (Folkman, 2001). Clearly there is some degree of

overlap with other models that refer to coping mechanisms (e.g., the four process model), but there is a difference in emphasis. Researchers in this field have particularly been trying to understand how cognitive appraisal impacts on responses and reactions to loss (e.g., Stroebe, Schut, & Stroebe, 2007).

Dual process model (DPM)

The DPM was developed from a cognitive stress perspective and is one of the most common theories currently in use and it is described as one of the most comprehensive and influential models of grief and bereavement (Stroebe & Schut, 2010). This model suggests that individuals will invariably oscillate between two different types of coping post-loss: loss-orientated and restoration-orientated coping. Oscillation is described as the central component of the model and is crucial to successful coping and optimal adjustment over time, due to its regulatory characteristics. Therefore, this model includes the stressors related with bereavement, cognitive coping strategies, and a flexible and dynamic process of oscillation where responses and reactions may alternate over time. This complex regulatory process of confrontation and avoidance seems to be the key to adaptive coping. A negative and painful focus is more likely to be identified in the *early days* of bereavement. Nevertheless, positive emotions and affects are also likely to become part of the process, as the time goes on. Thus, DPM places more emphasis on *how* people respond and cope with their experience than on the bereavement outcomes. However, Stroebe et al. (2007) later demonstrated that effective coping strategies can decrease mental and physical issues.

Traumatic model of bereavement

Smid, Kleber, Simone, Gersons and Boelen (2015) developed a cognitive stress model that draws both on models of post-traumatic distress and on theories of bereavement. The traumatic loss characteristics (unexpected, violent and sudden deaths) are likely to change beliefs and perceptions, as well as cognitive processing. Therefore, the

nature of death is likely to impact on the individual's adaptation. Their model explains ongoing and severe responses post-loss, as follows:

1. Inability to integrate the memory related with the traumatic loss/event (i.e., poorly elaborated in terms of where the event happened, what happened and what now) and failure in the connection information (*X* is dead) with future plans.

2. The post-loss changed beliefs and assumptions (e.g., trust, power, identity, and esteem) might lead to maladaptive cognitions and might constitute a barrier to 'recovery'.

3. The individual keeps searching for cues relevant to understanding how the person died, which is likely to exacerbate distress. Additionally, new potential stressors (e.g., new job, need of a different organisation on the family's daily life) might be perceived as more negative and stressful (attentional bias issues and depressive symptoms, for instance), impacting on the overall (mal)adaptation.

4. Attempts to avoid distress related to the event, as well as ruminating about key event elements and/or person who died is likely to be associated with negative emotions with this impacting on how the factual information about the loss is processed.

It is important to note that many other theories and concepts were developed, however those described above offer a more integrative view to explore violent-losses. In fact, the concepts outlined account for change and adaptation elements (e.g., health issues, changed views about the world), crucial elements to increase understanding about the individuals' responses post-homicide

Homicidal bereavement

Definition(s)

According to the statutory principles in the United Kingdom (UK; April, 2015), homicide is defined as an act of killing one person by another. In that sense, murder and manslaughter are the two criminal offences that constitute homicide. However, *murder* is defined as a premeditated act of killing, while *manslaughter* is without a premeditated intention to kill.

Within the literature, a diversity of terms are used to describe individuals bereaved by homicide, including surviving family members (survivors), co-victims of homicide, and secondary victims (e.g., Asaro, 1992, 2001; Spugen, 1998). This heterogeneity of definitions can create confusion both among researchers and practitioners, not least because some of these terms do not reflect the cause of death, are seen to focus more on the homicidal act itself or merely include family members (van Denderen, de Keijser, Kleen, & Boelen, 2014). Consequently, van Denderen and colleagues (2014) proposed the use of the term '*homicidally bereaved individuals',* which they argue provides a more suitable definition of the phenomenon as it addresses the cause of the death (i.e., homicide) and is broad enough to include the different relationships any person may have to the victim. Thus, the review will continue to use the term 'homicidally bereaved individuals' throughout.

Homicide: Prevalence

Many people are bereaved through homicide (murder or manslaughter) each year, both in the UK and internationally. Recent figures demonstrated that over a quarter of a million individuals were killed in 2015 by homicide[11] (United Nations Office on Drugs and Crime [UNODC], 2017). Nevertheless, it is estimated that per each homicide, multiple individuals (relatives and friends) are affected. In fact, Redmond (1989) estimated that, on average, seven to ten immediate family members of the victim are affected. Thus, their needs must be understood and addressed.

In brief, United Kingdom figures demonstrate that in 2015, 571 homicides occurred in England and Wales, 57 Scotland and 21 in Northern Ireland; equating to 1.8 homicides per day (Home Office Homicide Index, 2017). Other European examples, such as, Lithuania presented the highest rate (77 per million population) and Iceland the lowest (3.1), with other countries ranging in between, namely Greece (13.6), Portugal (11.9),

[11] Cross-national comparison should be conducted carefully due to the differences that exist between the legal definitions of offences in countries, the different methods of offence counting and recording and differences in the share of criminal offences that are not reported to or detected by law enforcement authorities.

England and Wales (11.7), France (11.4), Netherlands (9.1), Spain (8.9), Germany (8.6) and Switzerland (6.7). Finally, United States of America's figures show that 49 per million population were killed in 2015 (The Department of Justice and Federal Bureau of Investigation, 2015). However, given the variation in homicide definitions, as well as the differences in criminal justice systems/procedures and methodologies used, homicide rates from diverse countries should be interpreted with caution.

Homicidal bereavement experiences: impact(s)

"*This* [homicidal bereavement] *you cannot compare with any other experiences. Dad passed away last year, but it was natural, it was normal. He did not get killed*."

[Participant 012]

Nearly all individuals experience the death of a loved one during their lifetime. In fact, grief can be defined as an almost universal response to the loss of a loved one, albeit one that manifests in diverse ways. Approximately 45-50% of individuals tend to respond resiliently to a non-violent death. When the death occurs in 'normal' circumstances (Bonanno & Kaltman, 2001) the grief symptoms typically diminish after one to two years, which represents a 'normal grieving process' (Mancini & Bonanno, 2006). However, bereavement distress when violent circumstances are involved (e.g., homicide) seems to comprise a *different* form of grief that can be particularly severe and persist for many years.

These differences of grief reaction and processing have become a focal point of interest for both academics and professionals. The study of 'traumatic bereavement' experiences has increased in the last few decades. The first descriptive studies were conducted in 1970s, 1980s and were informed primarily by clinical practice (e.g., Black & Kaplan, 1988; Burgess, 1975, Pynoos & Eth, 1984; Rynearson, 1984; Spungen, 1998). These studies highlighted a variety of post-loss difficulties likely to occur following a homicide, as well as warned for the potential risk of psychosocial problems.

Empirical research[12] emerged in the late 1980s and 1990s, validating and extending the results from early studies, with this informing about psychopathology prevalence, coping patterns and effective strategies and therapy that are likely to help homicidally

[12] Rinear (1988) conducted the first survey with individuals bereaved by homicide demonstrating the main outcomes post-loss, mainly psychosocial and traumatic difficulties, changed/"*destroyed*" personal beliefs.

bereaved individuals. In fact, research has been divided in three main areas, mainly: 1) impacts post-homicide (e.g., psychological difficulties, family, social and financial difficulties); 2) what coping strategies individuals seem to engage with; and 3) effectiveness of psychological intervention.

Format of review

This review followed a conventional method of narratively synthesising the findings of literature retrieved from searches of computerized databases, as it was deemed to be more suitable as a starting point. Findings from over 100 records (including grey literature) demonstrated that research among homicidally bereaved individuals has increased in the last few decades, but it is also a *new area* when compared with other forms of violence, such as domestic and sexual abuse.

The next sections summarise the key areas in the literature, including legal and conceptual definitions, prevalence, impact and outcomes, as well as coping and resilience patterns. Finally, limitations, practical implications, as well as suggestions for future research will be also considered. Ninety seven studies conducted from 1975 to 2017 will be considered in this review.

In terms of methodology, and research designs, more recent studies have used quantitative or qualitative approaches, and very few adopted mixed method designs. Furthermore, the vast majority of studies reviewed were based on cross-sectional studies not enabling understanding of individuals' difficulties and needs over time. Validated measures were not always used, hence comparisons between studies and generalisation should be made carefully.

Research has mostly focused on the adult's experience of homicidal bereavement, in particular with parents. Nevertheless, some studies were conducted with children and adolescents traumatically bereaved (not necessarily by homicide; Layne, et al., in press) and homicidally bereaved (e.g., Salloum et al., 2001; Salloum, 2008). In fact, this seems to

be an area that needs further developments, especially when it is a matter of domestic homicide.

Almost all the studies were USA-based, although other countries are increasingly researching experiences of homicidal bereavement (e.g., the Netherlands). Nationally, and with the exception of a few notable studies (Casey, 2011; Dawson & Riches, 1998; Mezey, Evans, & Hobdell, 2002; Paterson, Chaston, & Malone, 2007; Gekoski, Adler, & Gray, 2013 Mueller-Johnson & Lanskey, 2014; Rock, 1998; Wright, 2015), limited research has been conducted looking at homicidal bereavement experiences. Therefore, this PhD is the first UK study using a longitudinal mixed methods approach and hopes to corroborate and extend the overall knowledge and contribute to better understand those going through such difficulties.

The next section will summarise the most commonly found impacts reported in the previous studies. Table 1 offers an overview about the main findings reviewed per study, which will then be summarised briefly below.

Table 1. Studies with homicidal bereavement individuals, in date order (N=97).

Authors (date) Country	Total N/n Homicide	Type of study	Focus	Main Results
Burgess (1975) USA	6	Client records	PTSD, socio-legal issues of the criminal justice process	▪ Physical issues: sleeping, headaches, palpitations, gastrointestinal upsets ▪ Traumatic responses, anger, guilt ▪ Social-Legal issues: lack of information and "*impersonal attitude of the court*", and self-blame, system as unfair ▪ Professional training is suggested
Rynearson (1984); USA	15	Qualitative-focused	PTSD Anger	▪ Psychological difficulties: cognitive, behavioural and affective reactions meeting DSM-III criteria for diagnosis of posttraumatic stress disorder
Getzel & Masters (1984); USA	356	Clinical records	Psychological difficulties	▪ Acute grief reactions, dysfunctional behavioural and social isolation
Peach & Klass (1987) USA	n/a	Participant observation	Psychological difficulties Legal processes	▪ Legal processes (length and duration) impact on grief processes ▪ Lack of knowledge about legal proceedings; Safety issues post-loss
Masters et al. (1987) USA	1182	Clinical records	PTSD World/Legal	▪ Traumatic reactions; negative role of the criminal justice system ▪ Trust and safety issues and need for social security

			views	
Rinear (1988)[13] USA	237	Quantitative-based	PTSD Self and world-views	▪ Trauma responses met APA criteria (1980) ▪ Vulnerability and perceptions of an unsafe and unpredictable world, with this increasing isolation
Rynearson (1988) USA	n/a	Clinical reports	Psychological difficulties	▪ Traumatic and grief responses and death imagines ▪ Changed world-views
Murphy, et al. (1988) USA	171/17 (suicide, homicide and car accident)	Quantitative-based (72h post-event, 4 months and 2 years assessments)	PTSD	▪ High levels of PTSD over time (more mothers than fathers) ▪ 87% mothers and 67% fathers reported PTSD symptoms 2 months post-event; 2 years after, 71% mothers and 32% fathers ▪ PTSD associated with poor job performance and poorer coping strategies (drinking and self-medicating); plus higher after homicide ▪ 31% of the mothers and 14% of fathers who did not receive therapy, presented clinical symptoms 2 years after the event
Amick-McMullan et al. (1989) USA	19	Quantitative-based	PTSD Criminal Justice	▪ Trauma-related responses (intrusions and avoidance) ▪ HB individuals reported greater scores when compared with victims of rape
Sprang et al., (1989) USA	n/a	Client records	Grief stages	▪ Denial, isolation, guilt, anger and resentment, depression and adaptation ▪ Police investigations, additional forms of victimisation
Amick-McMullan et al. (1991) USA	12.500/115	Qualitative-based using DSM-1II-R criteria for PTSD	PTSD	▪ 19.1% met all criteria for lifetime PTSD ▪ 5.2% met current PTSD criteria ▪ No differences between type of death and PTSD were found

[13] First survey-based study.

Gabriel (1992) USA	n/a	Clinical reports	Anniversary responses	▪ Overall, 30% of parents reported having experienced anniversary reactions described ▪ Anniversary reactions linked with depression, psychosis, suicide
Lyon et al. (1992) USA	n/a	Satisfaction reports - group intervention	Legal processes	▪ Education about grief and legal proceedings ▪ Group as decreasing isolation and providing support
Parkes (1993) USA	17	Client records	PTSD	▪ Intense PTSD symptoms over time (short-term therapy did not impact on the symptoms) ▪ Avoidance maintains high levels of psychopathology
Rynearson & McCreery (1993) USA	18	Clinical reports	PTSD Changed identity	▪ Traumatic and grief responses ▪ Changed world-views
Freedy et al. (1994) USA	120/62	Qualitative-based-based	PTSD	▪ 71% met lifetime PTSD criteria
Rynearson (1994) USA	237/32	Quantitative-based	PTSD	▪ Hither scores of PTSD among treatment-seeking individuals than non-seeking
Freeman et al. (1996) USA	15/15	Qualitative-based-based	Depression and PTSD (DSM-III-R)	▪ 80% developed a disorder, compared with the control group (10%) ▪ Depression, PTSD, and anxiety and internalised distress ▪ Avoidance and psychosocial impairments (with peers, for instance) ▪ Generalised fear and poor communication patterns ▪ Only three children were referred to professional support (aggressive behaviour)
Thompson et al. (1996) USA	150	Quantitative-based	Psychological issues and legal	▪ HB individuals were very dissatisfied with their experiences in the criminal justice system

			systems	
Wall & Levy (1996) USA	5	Clinical reports	Safety, social and relational narratives post-homicide	▪ Highlighted the importance of understanding individuals narratives and help them to create *new* (coherence and social efficacy)
Temple (1997) USA	5	Clinical reports	Psychological difficulties Client satisfaction	▪ Anger, depression and PTSD reported ▪ Contextually oriented therapy was described as helpful by the participants
Thompson & Vardaman (1997) USA	150	Quantitative-based	Psychological difficulties Religious coping	▪ High PTSD levels ▪ Religious support was positively related to wellbeing
Dawson and Riches (1998) UK	5	Qualitative-based	Social aspects of HB	▪ Lack of information about the criminal process ▪ Criminal proceedings might inhibit a 'normal grief reactions' ▪ At risk of social stigma or publicity (media)
Murphy et al. (1998) USA	171/17	Quantitative-based	Psychological distress	▪ Mothers presented greater levels of distress ▪ Distress decreased following a dimensional preventive 10-week intervention for mothers
Thompson et al. (1998) USA	150	Quantitative-based	Distress levels Pre, peri and post-event variables	▪ 26% of the sample PTSD and depression; HB individuals significantly more distressed than other two groups (other traumas and non-victims) ▪ Less years of education and more traumatic exposure, closer relationship with the victim, satisfaction with the notification process, economic role change and drug-related homicides were associated with higher levels of

				distress. Time since loss did not impact distress levels
Beard & Kashka (1999) USA	2	Clinical reports	Criminal process	▪ Insensitive treatment from the criminal justice system ▪ Lack of information about how the process progresses
Umbreit & Voss (2000) USA	5	Qualitative-based (case studies)	Restorative Justice	▪ Positive gains reported ▪ Mediation sessions between relatives and offender were described as healing experiences
Amour (2002); USA	14	Qualitative-based Hermeneutic phenomenology	Individuals' post-homicide experiences	▪ State and social milieu play an important role in shaping the post-homicide experience, as individuals can feel participants felt neglected ▪ Media, criminal processes and stigma linked with maladaptation ▪ PTSD reactions linked with personality change the notion of *wanting to go back*
Asaro (2001); USA	Case study	Clinical reports	Post-homicide experience	▪ Increasing risk for PTSD, CG and secondary victimisation ▪ Media intrusion and social stigma ▪ Deal with the criminal justice with lilt information
Asukai et al. (2001) Japan	13	Quantitative-based	PTSD, Grief Depression	▪ Baseline to 12 months follow-up: on complicated grief, intrusion, avoidance, hyperarousal, depression (p values < .001) ▪ Criteria for PTSD was not met at 12 months follow-up by 84.6% of the participants (n = 11)
Salloum et al. (2001) USA	89	Quantitative-based (pre and post-intervention)	PTSD	▪ Pre and post-interventions: PTSD scores decreased significantly. ▪ Length of time since the event did not impact pre and post-interventions scores; there were no differences between boys and girls
Wickie &	76/21	Quantitative-based	Grief	▪ Parents of murdered children had significantly more negative views

Martwit (2001) USA			Worldviews	regarding the benevolence of the world than parents bereaved by accident
Clements & Burgess (2002) USA	13 (children)	Qualitative-based	PTDS CG	▪ Narratives describe symptoms of PTSD and complicated grief ▪ The importance of accommodating the children's' needs on post-homicide
Dannemiller (2002) USA	11	Qualitative-based Grounded theory	Criminal justice system	▪ Negative Public response to the death ▪ Care and understanding, as well as providing information that is accurate, consistent, and complete were reported as the key elements
Mezey et al. (2002); UK	35 (incl. adults and children)	Quantitative-based and	Professional changes	▪ 49% had been employed pre-homicide, 27% lost their jobs pots-homicide ▪ All were getting support from Victims Support, and 66% had also sought support from other professional services ▪ 77% reported have also sought informal support ▪ High levels of PTSD, depression and anxiety were reported
Murphy et al. (2002) USA	120	Quantitative-based	PTSD	▪ 5 years after the deaths, 61% of the mothers and 62% of the fathers met diagnostic criteria for mental distress. 27.7% of the mothers and 12.5% of the fathers met diagnostic criteria for PTSD
Parappully et al. (2002) USA	16	Qualitative-based	Thriving after the event	▪ Positive impact on society, transformation of self and cognitive-emotional processes, finding meaning, compassion-greater adjustment ▪ Personal qualities, leadership, determination, positive minded, compassion, thankfulness, spirituality, social, professional support previous difficulties, self-care and communicating feelings facilitated the transformation
Adkins (2003)	2	Clinical report	CJS and	▪ Lack of information about the criminal processes

USA			Psychological difficulties	▪ Depression, anxiety and PTSD reported
Armour (2003) USA	38	Qualitative-based	Meaning making post-loss	▪ Importance of making sense of the event (specially the aftermath) linked with better adjustment
Clements & Vigil (2003) USA	15 children	Qualitative-based	Psychological difficulties	▪ Changed world-views and system of beliefs (inadequacy, dangerous world, uncertainty, lack of control) that are likely to compromise psychosocial growth and development
DeYoung and Buzzi (2003) USA	8	Qualitative-based	Post-loss experience	▪ Ambiguity of these HB and missing children ▪ To cry, to scream, to be angry was described as helpful ▪ Individuals found helpful to know that they are "*not alone*"
Horne (2003) USA	112	Clinical reports	Service description	▪ Intra-familial homicides used services during the initial 8-week crisis period following the homicide more than other individuals, but less afterwards ▪ Consideration of their relationships to perpetrators need to be taken in consideration
Miranda et al. (2003) USA	n/a	Clinical reports	Psychological difficulties	▪ Anxiety, depression and PTSD responses ▪ Legal processes as a potential secondary source of victimisation
Murphy et al. (2003a) USA	171/17	Longitudinal quantitative based	PTSD	▪ Twice more HB parents met PTSD criteria 2 years post-loss compared with the control group
Murphy et al. (2003b) USA	171/17	Longitudinal quantitative based	PTSD Gender	▪ A slower decrease of PTSD symptoms among HB individuals was not confirmed when compared with bereavement among suicide and accidents 5 years post-loss. Mother more PTSD than fathers

Murphy et al. (2003) USA	173/30	Mixed-method		▪ HB parents reported more PTSD symptoms ▪ 70% of the parents reported that it took them several years (3-4) to put their children's death into perspective
Kaltman & Bonanno (2003) USA	87/n/a	Quantitative-based	PTSS Depression	▪ Violent deaths (not homicide exclusively) linked with greater symptoms than natural deaths ▪ PTSD symptoms need to be addressed early in the therapy
King (2004) USA	7	Qualitative-based	Impact post-loss	▪ Mental health and social difficulties. Changed beliefs and attitudes about safety issues. Poor treatment by the criminal justice. Training should be provided to police and others working with HB individuals
Lewandowski et al. (2004) USA	237/91	Quantitative-based	Children's post-homicide experience	▪ Children exposed to their mothers murders or attempted murders were likely to have been exposed to prior marital violence ▪ Poor African American women and their children were more especially vulnerable than the other groups ▪ 35% of the children witnessed the homicide and 62% the attempts, but only 10% of these children received no or little intervention.
Mahoney & Charmaine (2004) Jamaica	5 children	Qualitative-based	Psychological difficulties	▪ PTSD, depression and anxiety, as well as cognitive/behavioural, and social-relational difficulties ▪ individual, social, and cultural elements linked with the impact post-loss
Asaro & Clements (2005); USA	n/a	Clinical reports	Sexual homicide	▪ Youth expose to sexual homicide linked with behavioural change, PTSD and depression
Goodrum (2005)	32	Qualitative-based	The news	▪ Emotional responses: upset, shock, disbelief and spontaneous action

Paterson et al. (2006) UK	n/a	Clinical reports	Needs pots-homicide	▪ High levels of emotional (e.g., PTDS) and physical difficulties (e.g., sleeping and eating difficulties). Information about legal and practical support, as well as self-help groups were perceived as helpful. Needs of specialised support with financial, domestic matters and emotional management (longer time)
Gross (2007) USA	n/a	Clinical reports	Emotional responses	▪ Dissimilar grief reactions when compared to 'normal bereavement': denial, shock, confusion, anger, guilt, powerlessness, depression, and a desperate search for understanding and meaning.
Malone (2007a) UK	Case studies	Qualitative	Emotional and practical aspects of traumatic bereavement and individuals' needs	▪ Lack of information about the criminal justice system and their advocacy needs ▪ Psychological difficulties (overwhelming emotional strain) ▪ Financial difficulties (e.g., funeral arrangements) and childcare ▪ Trial outcomes and offenders', nature of the custodial regime and release from the prison
Malone (2007b) UK	44 relatives Focus groups with personnel	Qualitative-based	Psychological impact of homicide Support needs	▪ Criminal justice process seen as additional source of distress ▪ High levels of distress, financial issues, childmind and school attendances. Individuals were satisfied with the support received, but some criticism was reported (e.g., short duration of support lack of knowledge of issues associated specifically with bereavement by homicide, volunteers or counsellors being overly affected by the bereaved person's grief, or not proactively offering help and not being able to give helpful information)
Salloum (2008) USA	45/45	Quantitative-based (pre and post-intervention)	PTSD	▪ Pre and post-treatment assessments: Significant decrease in posttraumatic stress. No statistically significant mean difference in post-test between younger children and older children. Older children lower PTSD

Blakley & Mehr (2008) USA	6 community groups	Qualitative-based	Empowerment strategies	▪ Trained personnel to facilitate the groups is an important requirement ▪ Address the lack of critical supportive services in rural areas (e.g., mental health, legal aid). Establish (rural) community support
Goordrum (2008) USA	32	Qualitative-based	Informal support	▪ Perceived inappropriate informal support (e.g., avoiding the topic, dramatic responses, telling them to move on)
Sharpe (2008) USA	5	Qualitative-based	Support network available Post-homicide experience of African-American individuals	▪ Informal social support and religion as primary source of support ▪ Need to incorporate formal social support systems (e.g., therapeutic interventions) was also reported ▪ Distrust of clinical (taboo) and ethnicity (therapy with Black people was preferable) was identified as a potential barrier to seeking support ▪ Fear of stigmatization
Miller (2009a) USA	n/a	Clinical reports	Health difficulties Coping	▪ Anxiety, depression and somatisation ▪ blame and anger ▪ Sleep and eating issues ▪ Avoidance and religious coping
Miller (2009b) USA	n/a	Clinical reports	Strategies to support HB individuals	▪ Physical and emotional self-control (relaxation, biofeedback, or meditation exercises that reduce arousal) ▪ Family role
Zinzow et al. (2009) USA	1.753/169	Qualitative-based	PTSD/Depression Substance abuse	▪ HB individuals more likely to report past-year PTSD, depression and substance abuse than non-victims
Burke e al. (2010) USA	54/54	Quantitative-based	Social support and Psychological	▪ Informal support (size), quantity of negative relationships, and levels of grief-specific formal support were linked with bereavement outcomes (more or less severity of PTSD, depression and CG). Informal support can

			issues	be perceived as unhelpful
Johnson (2010) USA	20	Qualitative-based	Meaning-making Coping patterns	▪ Meaning-making (re[constructed) meaning about their friends and lives post-homicide), spirituality and religion were perceived as a helpful coping strategy
Streteskya et al.(2010) USA	37	Qualitative-based	Communication with the criminal justice system and sense-making	▪ Negative views of the police and prosecutors due to the lack of information need to understand the crime ▪ Ethnicity linked with sense-making: constructions of meaning were based on perceptions of discrimination ▪ Better communication between families and legal personal were suggested
Casey (2011) UK	400 families	Quantitative-based	Effects post-loss and further needs	▪ Ongoing psychological difficulties and need for support ▪ The need for more awareness about help-seeking post-trial
Zinzow et al. (2011) USA	1,753/268	Follow-up Qualitative-based (2009)	PTSD Depression Substance abuse	▪ 39% of HB participants met criteria for PTSD ▪ 15% HB individuals met PTSD criteria compared with other victims of violence. HB individuals were more likely to meet criteria for two or three symptoms clusters
Burke et al. (2011) USA	46/46	Quantitative-based	Religious coping	▪ High levels of religious coping (both positive and negative) ▪ Negative religious coping linked with CG ▪ Positive religious coping unrelated to bereavement outcome ▪ CG prospectively predicted high levels of spiritual struggle 6 months later
Englebrecht (2011) USA	44 crim. justice personnel 23 family	Qualitative-based	Family's role in the justice process	▪ Importance of clarifying the nature and purpose of the inclusion of relatives in the criminal proceedings ▪ A more victim-oriented justice process was encouraged that might prevent exacerbation of psychological difficulties

	members			
McDevitt-Murphy et al. (2011) USA	54	Quantitative-based	PTSD Depression CG	▪ 18.5% participants screened positive for PTSD ▪ 54% of the individuals had scores suggesting at least mild depression ▪ 54.5% screened positive for complicated grief ▪ All of the PTSD-positive cases screening positive for complicated grief and depression ▪ <2 years post-loss individuals reported significantly higher levels of PTSD and anxiety severities than ≥ 2 years post-homicide. Depression and CG did not differ significantly.
Sharpe & Boyas (2011) USA	8	Qualitative-based	Coping strategies of African American post-homicide	▪ Primary coping strategies reported were spiritual/religious coping, meaning making, continuing a connection to the deceased, collective coping and caring for others and hiding their emotions
Johnson (2012) USA	21	Qualitative-based	Distress and identity development	▪ Loss of a friend to homicide was interconnected with the adolescent's identity development ▪ Religious identity commitments were reported
McDevitt-Murphy (2012) USA	54/54	Quantitative-based	PTSD CG Depression	▪ 18.5% screened positive for PTSD; 53.7% met criteria for mild depression and 54.5% for CG; <2 years post-loss, greater PTSD and anxiety scores; Time since loss not linked with depression or CG ▪ Time since the homicide was a significant predictor for anxiety and approached significance in predicting PTSD
Rheingold et al. (2012) USA	3.414/333	Quantitative-based	PTSD Depression	▪ Current PTSD: 6%; Past 6-months depression: 8% ▪ Drug use: 14% and alcohol use: 10%; Lower PTSD and depression among HB

			Substance abuse	
Tuck et al. (2012) USA	8	Quantitative-based pre-post-intervention and follow-ups	General wellbeing; PTDS; Depression; Grief; Religious coping	▪ Improvement on main domains: general & spiritual wellbeing, PTSD, grief, forgiveness, hopefulness, religious coping; exception of depression
Walijarvi et al. (2012) USA	102	Quantitative-based	support of a 8-week programme	▪ Increased grief resolution ▪ Group experience was an important element for participants
Williams et al. (2012) USA	47/47	Quantitative-based	Moderator variables and psychological difficulties	▪ Older individuals scored lower for PTSD ▪ Lower income and close contact with the victim was linked with CG scores. Lower CG and depression scores than a 6-months previous assessment
Gekoski et al. (2013) UK	14	Qualitative-based	Experiences with the CJS[14]	▪ Individuals reported secondary victimization from the CJS (e.g., feeling disempowered, ignored, side-lined, unsupported, and with a diminished faith in justice). Lack of information about the CJS
Sharpe et al (2013) USA	12/5	Qualitative-based	Impact and coping experiences with the	▪ Emotional responses: shock, anger, bitterness, despair, feeling numb and loss of purpose ▪ Both informal and formal support was reported ▪ Individual counselling was more often reported ▪ Alcohol/other drugs, avoidance and distancing from their relatives as a coping strategies ▪ HB individuals reported more religious/spiritual coping than individual's bereaved by suicide

[14] Criminal Justice System.

				▪ Support groups and education/training about grief responses were identified as important elements
Burke & Neimeyer (2014) USA	150/n/a	Quantitative-based	Spirituality and grief	▪ Use of religion as a positive resource in coping not linked unrelated to adjustment ▪ Maladaptive religious coping was consistently related to elevated grief ▪ HB individual had greatest difficulty accommodating the loss emotionally and spiritually
Saindon et al. (2014) USA	51/41	Quantitative-based	Tolerance to the intervention; Depression PTSD; CG	▪ Decreased depression, intrusion and traumatic grief symptoms (but not on avoidance symptoms). Severe symptoms at baseline had an effect on depressive, avoidance, traumatic grief symptoms and a marginally significant effect on intrusion symptoms
Wellman (2014) USA	15/15	Qualitative-based	Post-loss coping	▪ Most reported coping strategy was: role of religion in the grief process ▪ Other strategies included: art, work, family, formal counselling and support groups
van Denderen et al. (2014) The Netherlands	331	Quantitative-based	PTSD CG; Positive functioning	▪ Revenge (dispositional and situational) was positively associated with PTSD and CG symptoms and negatively with positive functioning ▪ Less situational revenge if the offender was known

Mueller-Johnson, K. & Lanskey, C. (2014) UK	17	Qualitative-based	Post-loss experience	▪ Experiences of families bereaved by murder and manslaughter with the criminal justice process.
Baddeley et al. (2015) USA	130/29	Quantitative-based	Psychological issues	▪ Homicide survivors were significantly more likely to report thoughts of revenge (45.3%) compared to suicide survivors (14.8%) ▪ All forms of imagery were associated with PTSD, depression, and CG
Rheingold et al. (2015) USA	91/62	Quantitative-based (pre/post-intervention and 12-months follow-up)	Depression CG PTSD	▪ Pre and post treatment: significant effect on depression, PTSD ▪ At 12-months follow-up: significantly lower depression, PTSD, CG. ▪ Time since loss did not impact. Reduction of CG for women. Better quality of relationship with deceased: higher post-treatment CG/PTSD; losing a child: showed greater decreases in avoidance. Homicidally bereaved> PTSD, avoidance & hyperarousal than suicide/accident
Rheingold & Williams (2015) USA	47	Quantitative-based and open question about barriers to care	Depression PTSD CG	▪ 57.4% met criteria for a mental disorder; depression was the most prevalent (48.9%); 34% scored positive for PTSD; 23.4% met CG criteria ▪ Main barriers were identified: barriers (e.g., insurance, cost of services) lack of information (e.g., not knowing who to contact), and health-related barriers (e.g., feeling too upset and health-related problems) ▪ MDE individuals reported more barriers ▪ Most of the individual were not involved in the criminal justice system, neither in mental health services ▪ Current MDE was linked with less satisfaction with services. Less overall service satisfaction by males

Wright (2015) UK	20	Qualitative-focused	HB individuals experiences with the GBP[15]	▪ Service and interaction as positive (compassionate and professional), last year's training has led to such outcomes ▪ Personal skills of the personal were highlighted as pivotal ▪ Some less positive views were reported at the early stages of the investigation and regular updates about the processes
Mastrocinque et al. (2015) USA	28	Qualitative-focused (focus groups)	Post-loss impacts and needs	▪ Emotional difficulties and hoe it would be important having psychological (specialised) assistance as soon as they hear the news ▪ Physical impacts (e.g., sleeping and eating issues) ▪ Social needs (e.g., meeting people with similar experiences) ▪ Spiritual needs: training/understanding the dynamic might be important to better support individuals
Boelen et al. (2016)The Netherlands	331/331	Quantitative-based	PTSD; CG; Cognitions Avoidance	▪ Greater symptoms among participants who had more negative cognitions and avoidance behaviours
Bottomley et al. (2015) USA	47	Quantitative-based	Social support and psychological difficulties	▪ Social support acts as a protective cushion against mental health sequelae ▪ Satisfaction with physical assistance predicted lower levels of depression, anxiety, and posttraumatic stress disorder levels 6 months later. Lower complicated grief symptoms at follow-up were predicted by less need for physical assistance
Pastia & Palys (2016) Canada	5	Qualitative-focused	CJS	▪ Receiving information (e.g., happened to their loved ones, role of the victim services, financial compensation) and being treated kindly were identified as the most important positives CJS elements

[15] Great Manchester Police.

				▪ Overall distrust of the justice system
Englebrecht et al. (2016) USA	14/14	Qualitative-focused	Post-loss experience	▪ Participants reported changes in their personalities and worldviews, employment ▪ Finding support and speak about their experience was the most coping strategy reported following by wanting to adjust to the new reality ▪ Avoidance and creating distance (e.g., moving another city; pretending that it did not happen) and substance abuse were also identified as coping strategies. Religion coping for a small number
van Denderen, et al. (2016) The Netherlands	312	Quantitative-based	PTSD CG	▪ PTSD prevalence was PTSD was 30.9% and 37.5% and CG was CG, the prevalence was 82.7% and 80.6% in the two groups analyses ▪ Females reported greeter symptomatology than males ▪ Lower PTSD and CG symptoms linked with (more) time since loss ▪ Parents reported higher levels of psychological issues than other relatives. Relationship with the offender did not impact on the outcomes, but the conviction of the offender impacted PTSD and CG scores (ongoing processes greater symptoms)
Mahat-Shamir & Leichtentritt (2016) Israel	12	Qualitative-focused	Meaning reconstruction	▪ Neglected individuals in Israel ▪ Participants identified personal and social changes ▪ Socially changed (the mother or the killed person) and the socials rules to ‘proper’ grief as unhelpful for meaning-making

Alisic et al. (2017) The Netherlands	256/137	Quantitative-focused	Domestic homicide	▪ Children were 7.4 years old (on average) at the time of the domestic homicide and most of them lost their mothers lost their mother (87.1%) ▪ 58.7% of the children were at the location when the homicide occurred ▪ 67.7% of the children were exposed to prior violence with 43.1% having not had received professional support
Neimeyer & Burke (2017) USA	59/n/a	Qualitative-focused	Meaning reconstruction	▪ Violently bereaved individuals endorsed more negative religious coping ▪ Depression was associated with greater spiritual crisis ▪ Cause of death did not mediate the relationship between spiritual coping and depressive symptomatology
van Wijk et al. (2017) The Netherlands	28	Qualitative-based (monitored for 63 months on average)	Long-term impact Psychological difficulties	▪ Decreasing of issues over time (less intense), however emotional difficulties might increase during the criminal process and sentencing and on certain occasions ▪ Long-term support and care is needed among this population ▪ Physical problems were reported and exacerbated by the event (e.g., e headaches, stomach and bowel complaints, sleeping problems and tiredness, cardiac complaints and loss of appetite) ▪ Less social contact, financial difficulties and media ▪ Lack of information about the legal process

Psychological difficulties

PTSD

PTSD or traumatic responses/symptoms can occur post-exposure to traumatic/adverse events (e.g., rape, violence). In fact, it is estimated that lifetime prevalence of PTSD is 7.8% (using DSM–III–R criteria; Kessler et al., 1995). With reference to the fifth and most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association [APA], 2013), four clusters are considered for diagnosis, including: intrusions, avoidance, negative alterations in cognitions and mood, and alternations in arousal and reactivity (APA, 2013). Symptoms are likely to include very intense and aversive details related to the traumatic event, frequent, intrusive, involuntary distressing memories and dreams about the traumatic event, dissociative reactions, prolonged and intense psychological distress, avoidance of stimulus associated with the event (e.g., memories, thoughts, feelings, people, places, objects), as well as negative alterations in cognitions and mood.

Direct exposure to an event is thought to increase the risk of PTSD when compared with indirect exposure (11.1 % vs. 7.3%, respectively; Breslau, 2002). However, it was demonstrated that homicidally bereaved individuals are likely to develop similar (or even greater) PTSD levels of distress than individuals exposed to other traumatic events (e.g., assault, rape; Amick-McMullan et al., 1989).

Regarding homicidal bereavement research, the vast majority of the studies has focused on PTSD responses. The main conclusion is that homicidally bereaved individuals report high rates of traumatic responses post-loss - both adults (e.g., Boelen, et al., 2016; Rheingold & Williams; Rheingold, et al., 2015; Rheingold et al., 2012), as well as children and adolescents (e.g., Salloum et al., 2001; Salloum, 2007). Despite unsurprising variations between studies, rates of PTSD among these individuals were found to be clinically significant (according to the DSM criteria).

With regards to the different violent cause of death, mixed results were found with respect to the severity of symptoms developed. Some studies concluded that homicidal bereaved individuals reported more severe PTSD when compared with individuals bereaved by other traumatic bereavement, such as suicide and accidents (e.g., Baddeley et al., 2015; Freeman, Shaffer, & Smit, 1996; Murphy et al., 1988; Murphy et al., 2003a, 2003b; Rheingold et al., 2015; Thompson et al., 1998; Zinzow et al., 2011; Zinzow et al., 2009). On the other hand, no differences by type of death were found in another study (Amick-McMullan et al., 1991).

Little is known about the progression of PTSD symptoms over time, due to the cross-sectional nature of the vast majority of the studies. Nevertheless, a few studies have demonstrated that mothers reported higher PTSD symptomatology than fathers at the three time-points assessment post-loss. Which is also in line with the Kessler et al. (1995) paper, which reported females are more at risk of developing PTSD as opposed to males. Furthermore, 31% of the mothers and 14% of fathers who did not receive therapy, presented clinical symptoms two years after the event (Murphy et al., 1989). Murphy, Johnson and Lohan (2002) found that 27.7% of the mothers and 12.5% of the fathers met diagnostic criteria for PTSD five years after the homicide. Moreover, less time since loss (<2 years) was linked with higher levels of PTSD among two studies (Lawson & Katherine, 2011; McDevitt-Murphy et al., 2012). In the same way, more time since loss was linked with lower PTSD severity in another study (van Denderen et al., 2016) and PTSD responses seem to decrease following psychological interventions. For example, in one study, criteria for PTSD was not met at 12 months follow-up by 84.6% (n=11) of the participants (N=13; Asukai, Tsuruta, & Saito; 2001). Rheingold et al. (2015) have also reported lower PTSD symptoms across time (from pre to post-intervention and further 12 months follow-up). Finally, treatment seekers reported higher PTSD symptoms compared with non-treatment seeking (Rynearson, 1995). In addition, among children samples,

PTSD scores were reported as having had decreased from pre to post-intervention (Salloum et al., 2001; Salloum, 2007).

Complicated grief

Overall, research on the matters of death and dying among adults, children and adolescents found that most people are able to grieve and adapt (Prigerson, 2004). In fact, the vast majority of the bereaved individuals will respond to the loss resiliently with or without support, demonstrating healthy levels of psychological and physical functioning in the first 12 months post-loss (Bonanno, 2004). Nevertheless, around 10% of individuals will required further support (Shear et al., 2011). For those ongoing grief responses (in particular intense yearning, searching for the deceased, disbelief about the death, an inability to accept the loss, and experiencing intrusive thoughts/images of the death) may all contribute to a persistence in grief response (Prigerson et al., 1995). In addition, individuals might be unable to work and/or experience decreased health and social functioning.

In some ways, these grief responses do not seem to be particularly different from what it is expected to be a 'normal grief'. However, the main differences are the prolonged impaired ability to function, as well the longer duration of symptoms (Shear, 2015). This has been categorised as complicated grief[16] (CG; Currier, Holland, & Neimeyer, 2006; Kersting, Brähler, Glaesmer, & Wagner, 2011). In fact, the recognition of *different* grief responses (when compared to 'normal'/expected grief responses) led to the development of specific diagnostic criteria for CG (Prigerson et al., 1995). However, CG is not currently recognised as an independent mental disorder by either the DSM-V or the International Classification of Diseases-10 (ICD-10) and further research is needed.[17]

[16] CG is also termed as *prolonged grief disorder* (Boelen, Van de Schoot, Van den Hout, De Keijser, & Van den Bout, 2010), *complicated grief disorder* (Maercker, & Znoj, 2010), *pathological grief* (Jacobs, 1993), *traumatic grief* (Jacobs, Mazure, & Prigerson, 2000), and *persistent complex bereavement disorder* (PCBD, American Psychiatric Association, 2013).

[17] CG is termed as *Persistent Complex Bereavement Disorder* in the DSM-5.

Regarding the CG prevalence and taking in to consideration the reviewed studies, the cause of death, as well as time since loss seem to be linked with the severity of symptoms. Furthermore, the general conclusion in research is that some risk elements can be linked to CG responses, including age of the deceased, previous loss experiences, anticipation/or not of the death, female gender, pre-existing mental health difficulties, close relationship with the person who died, substance abuse and lack of social support (Shear, 2015).

Regarding the nature of the losses, some studies have demonstrated that experiencing unexpected, sudden and violent losses was linked with greater CG responses (e.g., Currier et al, 2006; Shear, 2015; Parkes, 1993). However, evidence-based research is somewhat limited among homicidally bereaved individuals, therefore it is difficult to estimate the CG prevalence (Rynearson, Schut, & Stroebe, 2013). Despite that, the review studies informed about high levels of CG among those individuals, as well as some of the variables that seem to impact on the symptoms severity. For example, 54.5% of the individuals screened positive for CG and time since loss was not linked with the CG response (McDevitt-Murphy et al., 2012). In other studies, CG responses varied from 23.4% of positive CG-cases to 83%, (Rheingold & Williams, 2015; van Denderen et al., 2016).

In terms of associated factors, revenge (dispositional and situational) was positively associated with CG symptoms and negatively with positive functioning (van Denderen et al., 2014). In addition, imagery about the death/deceased (Baddeley et al., 2015), lower income and closer contact with the victim were associated with CG (Williams et al., 2012), as well as negative cognitions and avoidance behaviours (Boelen et al., 2016). The relationship with the offender did not impact on the outcomes, but the conviction of the offender impacted on CG scores (with ongoing processes reporting greater symptoms). Perceived available informal support (size), quantity of negative relationships, and levels of grief-specific formal support were linked with CG responses (Burke et al., 2010).

Perhaps unsurprisingly, in one study all PTSD-positive cases also met the criteria for CG and depression (McDevitt-Murphy et al., 2012). However, as with other forms of grief, CG can be responsive to interventions (Asukai, et al., 2001; Rheingold et al., 2015; Saindon et al., 2014).

Depression and substance abuse

Findings from the reviewed literature have also reported other psychological difficulties likely to occur post-homicide, mainly depression. Burke et al. (2012) demonstrated that the mean score for depression was 15.43 (higher than a minimal depression cut-off 10.9). Furthermore, McDevitt-Murphy et al. (2012) looked at the same sample finding that 53.7% scored positive for mild depression. Moreover, 8% of the participants (n=333) screened positive for past 6-months depression (Rheingold et al., 2012) and depression was the most prevalent (48.9%) mental disorder among 47 homicidally bereaved individuals. Among the same sample, individuals who screened positive for depression identified more barriers to recovery, as well as greater dissatisfaction with the services (Rheingold & Williams, 2015).

Perceived available informal support (size), quantity of negative relationships, and levels of grief-specific formal support were linked with bereavement outcomes (e.g., severity of depression; Burke et al., 2010). Another study demonstrated that homicidally bereaved individuals were more likely to report past-year depression when compared with other forms of bereavement (Zinzow et al., 2009). Similarly, data from clinical reports have also demonstrated the development of depressive symptoms post-homicide (e.g., Adkins, 2003; Miller, 2009a, Miranda et al., 2003; Temple, 1997; Thompson et al., 1998). In terms of depression-related symptomatology post-intervention, some studies reported diminished symptoms (Asukai et al., 2011; Rheingold et al., 2015; Saindon et al., 2014).

One qualitative study (based on DSM-III-R criteria; Freeman, Shaffer, & Smit, 1996) reported that 80% (N=15) of the homicidally bereaved youths (7-18 years) developed a disorder, compared to 10% in the healthy control group. Depression was most

reported. In addition, a qualitative study showed reported depression as an outcome among five Jamaican children (Mahoney & Charmaine, 2004).

Importantly, the vast majority of the literature reviewed described other emotional responses that are likely to be related with overall psychological issues post-homicide. In fact, findings suggest that individuals experience strong feelings of anger (Burgess, 1975; DeYoung & Buzzi, 2003; Getzel & Masters, 1984; Gross, 2007; Miller, 2009a; Rynearson, 1984; Sharpe et al., 2013; Sprang et al., 1989; Temple, 1997), self-blame and guilt (Burgess, 1975; Clements & Burgess, 2002; Gross, 2007; Miller 2009a; Sprang et al., 1989), terror, shock, apathy, disbelief and powerless (Getzel et al., 1984; Goodrum, 2005; Gross, 2007; Sharpe et al., 2013) and confusion (Gross, 2007).

Finally, data it is limited with regards to alcohol and/or drug abuse post-homicide. However, it was an outcome reported in several studies, mainly qualitative in nature (Englebrecht et al., 2016; Sharpe et al., 2013; Zinzow et al., 2009; Zinzow et al., 2011). One quantitative study (Rheingold et al., 2012) reported 14% drug use and 10% alcohol abuse among the bereaved individuals sample (N=333). Finally, another study found a link between PTSD and poorer coping strategies, including drinking (Murphy, Braun et al., 1999).

Other impacts

Physical health difficulties

In addition to the psychological difficulties described above, homicidally bereaved individuals often report a general decline in physical condition and quality of life post-loss. (e.g., Asaro, 1992). This can occur either in the form of a direct response to the homicidal bereavement or as a result of the psychological difficulties that are experienced post homicidal bereavement experience, for example, physical symptoms associated with PTSD, such as headaches, gastrointestinal problems, and increased fright responses. In fact, those symptoms have been reported in some of the studies reviewed. These include sleeping and eating difficulties (Burgess, 1975; Mastrocinque, et al., 2015; Miller, 2009a;

Paterson et al., 2006; van Wijk et al., 2017), but also headaches, stomach and bowel complaints, sleeping problems, tiredness, and cardiac complaints (Burgess, 1975; van Wijk et al., 2017). Physical health difficulties also commonly involve shortness of breath, palpitations, restlessness and insomnia (Rheingold et al., 2015). However, less is known about how individual differences in terms of cause of death and relationship with the victim might be linked to a somatising response.

Interpersonal and social issues

On a personal level, an experience of homicidal bereavement is likely to lead to long-term changes to one's self-perception and role in the wider system. For some, the "*story of violent dying becomes the only narrative in their lives*" (Rynearson, 2001 p. 21) and this has been reported as impacting on the individuals' overall worldviews, beliefs and trust. Early research highlighted that individuals may cease to trust their previous beliefs or those of others (Currier et al., 2006; Janoff-Bulman, 1992; Rynearson & McCreery, 1993) and the world in general. In fact, some studies have demonstrated that individuals start to see the world as unsafe and unpredictable (e.g., Clements & Vigil, 2003; Englebrecht, et al., 2016; Friedman, & Getzel, 2003; Rinear, 1988) Furthermore, feelings of alienation and social isolation were reported (Miller, 2009; Rinear, 1988; van Wijk et al., 2017). Finally, one study (Amour, 2002) has reported that some individuals find it hard to deal with their new 'identity' as a bereaved person and often wish they could go back to their 'normal', pre-event personality (Mahat-Shamir & Leichtentritt, 2016).

Overall, this self-disorientation during an emotional roller-coaster can increase the likelihood of other disorders, such as anxiety and/or depression, as well as somatisation (APA, 2013), as well as increased isolation and social difficulties. Hence, there seem to be high degrees of comorbidity. Further, the literature reviewed has highlighted that individuals might internalise an idea of themselves as deviant or atypical due to the homicide experience, and isolate themselves, as a result. Furthermore, some studies have described the potential for social-stigma and the negative effect of social attitudes on the

individuals' adjustment (Armour, 2007; Asaro, 2001; King, 2004; Mahoney & Charmaine, 2004). Importantly, those perceptions are likely to (negatively) impact on how/what coping strategies individuals use to better adjust, as will be discussed later in this chapter. Finally, it is important to note that individuals might also develop self-stigma (e.g., documented in the psychosis literature, for example; Rüsch et al., 2014), where one's view of themselves is reinforced by those around them and the services within which they need to operate. However, this needs further research among homicidally bereaved individuals.

Economic and professional difficulties

In terms of direct impacts post-homicide, the reviewed literature highlighted the potential change of the individuals' professional roles (for a while or, for some, forever), as well as decreased income (e.g., Malone, 2007a, 2007b; Paterson et al., 2006; Thompson et al., 1988; van Wijk et al., 2017; Williams et al., 2012). Thus, this was described as having additional effects, such as the homicidally bereaved having to work longer hours than previously, having to return to work prior to a state of readiness and/or having to look for employment when previously they did not work, which comes alongside to the funeral arrangements, negotiating the criminal justice system and the more personal impacts.

Potential moderator variables

Circumstances of the death

Previous research has already demonstrated that violent loss leads to more severe emotional distress than non-violent loss (e.g., Boelen et al., 2015; Boelen, 2015), due to the particular characteristics of a death by homicide. Indeed, homicides tend to be violent, sudden and unexpected acts (Kristensen et al., 2012) with this increasing PTSD responses post-loss (Boelen, 2015; Bonanno, Galea, & Vlahov, 2006; Rheingold et al., 2015).

Furthermore, homicidal bereavement when compared with other violent/traumatic losses (suicide and accident; Murphy et al., 1999, 2003a, 2003b; Zinzow et al., 2009)

seems to lead to increased psychopathology levels and poor overall functioning, as mentioned above. Beyond the impact of all homicides, some involve an additionally horrific scenario, including torture (Asaro & Clements, 2005). In fact, some individuals may re-experience crime-related images/thoughts (e.g., crime scene, body of the victim) with this increasing the risk for PTSD and CG responses, as described previously.

Research has also highlighted the potential inability to find the meaning of a violent experience of bereavement, with this differing among non-violent losses. Indeed, the failure of meaning-making for violent losses relate to the change of one's fundamental beliefs and assumptions about self and others (Currier et al., 2006; Janoff-Bulman, 1992; Rynearson, 1988) leading to the development of anger, unfaithfulness and/or trust issues. Thus, this seems to be reinforcing the overall distress described above. However, some studies did not find differences between those types of losses (Amick-McMullan et al., 1999; Freedy et al., 1994; Murphy et al., 2003a) and therefore more research is needed. Finally, lower rates of depression, substance abuse were lower among homicidally bereaved individuals compared with suicide and accident (Rheingold et al., 2012).

Legal proceedings and media coverage

Death by homicide seems to include very particular elements not often involved when non-violent losses occur. Firstly, some of the reviewed research notes additional difficulties and distress due to the legal and criminal processes. Several studies have described individuals' perceptions about the legal-criminal processes, with the vast majority describing poor experiences, especially due to the lack of information about how it works and progress over time (Armour & Umbreit, 2006; Asaro, 2001; Beard & Kashka, 1999; Burgess, 1975; Dawson & Riches, 1999; King; 2004; Malone, 2007a, 2007b; Paterson et al., 2006; Thompson et al., 1996; van Wijk et al., 2017). Furthermore, the ongoing legal processes and sentencing were linked to increased distress among individuals, as well as with potentially inhibiting 'normal grief reactions' (Beard & Kashka, 1999). Finally, for some, the "*impersonal attitude of the court*" (Burgess, 1975, p.

396) was highlighted as a negative element and highlighted the need for a service that offers care and understanding, as well as provides information that is accurate, consistent, and complete (Adkins, 2003, King, 2004; Streteskya, Shelley, Hogan, & Unnithanb, 2010). Furthermore, a more victim-oriented justice process was encouraged, which might prevent the exacerbation of psychological difficulties post-homicide and secondary victimisation (Englebrecht, 2011).

Regarding the media coverage post-homicide, some studies have reported its potential negative effects, with media intrusion described as an additional stressor. Family and friends might see their loved ones' stories publicised without their consent, which this been linked with overall distress (e.g., Armour, 2002; Asaro, 2001; Dawson & Riches, 1998; van Wijk et al., 2017).

Furthermore, the negative impacts of media coverage have led to suggestions that training on 'emotional literacy' should be provided to allow journalists to engage with and empower homicidally bereaved individuals (Malone, 2007; Vanacker & Breslin, 2006; Wellman, 2016). In that sense, individuals could potentially benefit from ethical journalism and an increase in society awareness, as well help people bereaved in similar circumstances.

Victim and perpetrator characteristics

Very little it is known about how the different types of relationships with the victim (e.g., mother, sibling, partner), quality of the relationship (i.e., closeness), as well as the age of the victim (children vs non-children) impact on the post-homicide psychopathology and progression of symptoms. Of the limited studies, it appears that closer relationship with the victim was linked with higher post-treatment CG and PTSD symptoms, but also general greater CG symptoms and distress (Burke et al., 2012; Thompson et al., 1998). Parents reported more severe PTSD and CG symptoms than other relatives (van Denderen et al., 2016). However, the age of the child killed (child under 18 years versus adult-child) did not impact on the psychological difficulties. In fact, whatever the age of the child

(including adult children), they often refer to it as an 'unnatural' time to die as the expectation that you will die before your own children has been overturned (Asaro, 1992). More research is still needed to better understand how this might impact/moderate the outcomes and progression of psychopathology over time.

Regarding the relationship with the offender (known vs unknown) and its potential effects on the homicide outcomes, once again the research is very limited and inconclusive. The only study found demonstrated that the relationship with the offender did not impact on the outcomes, but ongoing process and the conviction of the offender impacted on PTSD and CG scores (ongoing processes greater symptoms; van Denderen et al., 2016). Furthermore, limited is known about the dual grief processes, where the individuals are close relatives to the victim and offender (e.g., victim's and offender's father). Further research should look in to this closer, as it would not be surprisingly if this particular group presented greater psychological difficulties.

Time since loss and progression of symptoms

Only a few studies have considered the time since loss as a potential moderator of psychopathology; the vast majority of the studies conducted to date are cross-sectional in nature. Therefore, results should be carefully taken and further research is recommended.

PTSD symptoms seem to slightly decrease over a two-year period for homicidally bereaved parents, with fathers reporting greater decreases (Murphy et al., 1999). Parkes (1993) described reduced PTSD symptoms over time, and emphasises that short-term interventions seem to be insufficient. Furthermore, time since the homicide was a significant predictor for anxiety and approached significance in predicting PTSD among 54 individuals (McDevitt-Murphy et al., 2012), as well as linked with lower PTSD and CG symptoms (van Denderen et al., 2016). Finally, CG and depression symptoms decreased over the six month study period, but not in PTSD scores. In the same sample, participants reported higher symptoms of anxiety and PTSD within the first two years post-loss rather

than later (Williams et al., 2012). Hence, it is possible that for some individuals, symptoms decrease over time even without intervention; this is an area for further research.

On the other hand, some studies found that time since loss did not impact on the outcomes (Amick-McMullan et al., 1991; Rheingold et al., 2015.; Thompson et al., 1998). Moreover, no links were found between time since loss and depression or CG symptoms (McDevitt-Murphy et al., 2012). Similarly, time since loss did not impact PTSD symptoms among sample with children and adolescents (Salloum et al., 2001). Finally, a recent longitudinal qualitative study reported that psychological difficulties are likely to decrease over time, however certain occasions, such as anniversaries and religious celebrations might increase symptoms (van Wijk, et al., 2017).

Coping patterns

Interpersonal characteristics define how individuals react and respond to different events. Skills, strengths, resources, support, coping strategies and resilience vary from one individual to another, and might impact on how effectively individuals deal with stressful events (Asaro & Clements, 2005). However, coping styles for homicidally bereaved individuals have yet to be fully explored. One of the few studies noted that homicidally bereaved individuals tend to focus on keeping themselves busy (e.g., domestic tasks, job/career, being an active member in the family, physical exercise; Asaro, 2001). However, this may provide an '*illusion*' of coping by avoiding thoughts and/or feelings related to the traumatic bereavement experience rather than actual coping (Meier et al., 2013).

Furthermore, another key coping strategy for those individuals seems to be the ability to find meaning about their experiences. Some studies have found a link between a better adjustment and meaning-making (Armour, 2003; Gross, 2007; Johnson, 2010; Parappully et al., 2002; Streteskya et al., 2010; Sharpe & Boyas, 2011). In fact, overall, results have highlighted the importance of process and contextualising the homicide, as it

links with the development of negative and maladaptive cognitions (e.g., "*if only I have done X*") possibly due to maintaining levels of distress (Mahat-Shamir & Leichtentritt, 2016; Neimeyer & Burke, 2017).

In addition, and sometimes seen as related with the meaning-making process, religion/spiritual coping is seen as helpful for some, offering an important resource for practical support and a sense of community (Sharpe & Boyas, 2011; Thompson & Vardaman, 1997). However, it is still unclear if religious coping and engagement with spiritual activities is an indicator of positive psychological adjustment for all individuals, as noted by Bruke et al. (2011).

On the contrary, some other studies demonstrated that religion/spirituality might not be perceived as helpful and comforting for all homicidally bereaved individuals (e.g., Johnson, 2010; Thompson & Vardaman, 1997). In fact, an inability to make (religious) sense of the traumatic experience could bring more complications to the grieving process (Neimeyer et al., 2010) and affect individuals' beliefs and perceptions about their religion/spirituality. This may include inducing a religious/spiritual crisis (Asaro, 2001; Burke et al., 2011), with feelings such as anger and self-questioning about God's power, sense of (non-)community and/or unfairness. Furthermore, in one study, greater PTSD symptoms were linked with the use of poorer coping strategies, such as drinking and self-medicating; Murphy, 1989).

Another coping strategy adopted by the individuals is avoiding places, situations and thoughts (termed as anxious avoidance) and social interactions (depressive avoidance) as a coping strategy (e.g., Amick-McMullan et al., 1989; Boelen et al., 2016; Burgess 1975; Englebrecht et al., 2016; Freeman et al., 1996; Miller, 2009; Parkes, 1993; Rheingold et al., 2015; Saindon et al., 2014; Sharpe et al., 2013). This might maintain / exacerbate psychological difficulties and therefore should be incorporated in early clinical formulations.

Formal support

Formal support (e.g., professional help) is described as crucial for the individual's adjustment. In fact, some studies have demonstrated that group interventions with psychoeducational elements were often identified as helpful, by offering the opportunity for sharing and increasing support (e.g., Blakley & Mehr, 2008; Parappully et al., 2002; Paterson et al., 2006; Sharpe et al., 2013; Walijarvi, et al., 2012).

Support groups may be established through hospitals, churches or social service agencies that lend an atmosphere of support and empathy, which may normalise their reactions, responses, thoughts, feelings and fears. However, such groups may not be available for homicidally bereaved individuals. Thus, the field would benefit from a systematic analysis of the literature focused on the interventions available in such circumstances. Importantly it is still unclear how individuals' needs change over time. Thus, further studies are needed to gain a longer perspective about individuals' needs longitudinally.

Informal support

Formal support was described as a coping strategy in several of the reviewed studies. In fact, less or poor quality informal support was linked with worse outcomes (PTSD, depression and CG severity; Burke et al., 2010; Mezey et al., 2002; Sharpe et al., 2013), as well as the first source of support (Sharpe, 2008).

Whilst undoubtedly useful at times, informal support mechanisms that involve support from the family, friends, neighbours or other relatives might not always be perceived as helpful or supportive, given that people are dealing with their own reaction to the loss and/or are uncertain how best to show support (Burke et al., 2010; Francis, 1997; Goodrum, 2008; Sharpe, 2008). Indeed, informal support can even sometimes be perceived as inappropriate (e.g., refusal to discuss the topic and/or by body language), as well as increase feelings of pressure from social norms about appropriate expressions of grief and length of time – the notion of *"moving on*" (Goodrum, 2008; Mahat-Shamir & Leichtentritt, 2016). On the other hand, sometimes individuals who are trying to find help

to focus beyond the traumatic experience perceive the other's attempt at support as uncomfortable, unfair and narrow (Asaro, 1992; Goodrum, 2008).

Social support may be limited by other individuals' uncertainty about the best way to offer support (especially if the homicide has particularly difficult elements), leading some homicidally bereaved individuals to feel that close friends and even some family members are not 'available' (Clements & Burgess, 2002). Thus, social awareness about how to respond to grief in general and to homicidal grief, in particular, could improve individuals' adjustment.

Resilience

The term 'resilience' can be defined as the capacity to adapt to a significantly adverse experience, such as trauma, abuse, bereavement, significant parental mental illness and deprivation (Bonanno, 2005; Luthar, 2003). Early work on resilience focused on children growing up in adverse situations (Luthar, 2003).

One question is how resilience might be mediated through individual and situational factors. For example, interpersonal features, such as flexible personality type (Bonanno & Mancini, 2008), adaptive coping resources (e.g., pragmatic coping; Bonanno, 2008), successful past experiences of supportive and healthy relationships, and good community resources have all been associated with resilient outcomes following trauma, including maltreatment (Garmezy & Tellegen, 1984; O'Dougherty-Wright & Masten, 2005). Other variables related to a resilient response may include familial support and stability, friendships, social support, career success, spirituality, and community integrity (Marriott & Hamilton-Giachritsis, 2014). However, as noted by Bonanno and Mancini (2008), the co-occurrence of these factors will impact on the different resiliency paths of each individual. Furthermore, studies have demonstrated that previous resilience to a prior experience of extreme distress seems to predict resilience in future difficult circumstances (Breslau, 2002). This element is crucial when developing clinical interventions, as it can be reflected and used as an empowerment tool.

More recently, interest has turned to the association between resilience and loss (Bonanno, 2004). After a bereavement, some people report an overwhelming incapacity to function 'normally' for years afterwards, whereas others can adjust relatively well without professional support (Bonanno, 2005). Conversely, a complete absence of distress following a loss could also be considered an atypical outcome that might impact negatively in the future (Middleton et al., 1993). For instance, relatively short-term symptoms of depression can be considered a 'normal' response to a bereavement; for that reason, DSM-V excludes individuals bereaved for less than two months for a diagnosis of major depressive disorder (APA, 2013). However, to the best of the authors' knowledge, to date there has been no study conducted specifically on resilience among homicidally bereaved individuals.

Discussion

This chapter reviewed some of the general bereavement models to provide a comprehensive theoretical framework about homicidal experiences. In fact, the theoretical models described above can be combined to maximise the understanding of a homicidal bereavement experience; it was noted that the DPM of coping with bereavement and meaning-making theories were compatible with HB in important ways (Parkes, 1971; Stroebe & Schut, 2015; Stroebe et al., 2017). In fact, those models focus on loss, change and adaptation (e.g., health issues, changed views about the world), crucial elements to increase understanding about the individuals' responses post-homicide. Thus, they are likely to inform clinical formulations, research, as well as psychological interventions.

Taking in to consideration the focus of this PhD, exploring experiences of homicidal bereavement (only), it was understood that three models could offer richer and more flexible approaches to understand homicidal bereavement experiences, mainly the traumatic grief model (Smid et al., 2015), the four-component model (Bonnanno & Kaltman, 1999) and DPM (Stroebe, et al., 2010; Stroebe, et al., 2007).

Secondly, the homicidal bereavement research reviewed identified high levels of psychopathology likely to occur post-loss. Indeed, PTSD, CG and depression were the most reported symptoms. Moreover, symptoms and overall maladjustment are described as ongoing. In fact, research has shown that violent losses (not homicide exclusively) tend to lead to different grief responses, with violent deaths leading to greater and more severe emotional distress compared to the non-violent losses (Boelen et al., 2015; Boelen, 2015; Kristensen et al., 2012).

Several key elements have been identified as reasons why violent losses are linked with greater distress. The sudden and unexpected, but specifically the violent nature of the deaths seem to be key important elements that help to understand the negative outcomes. Some studies have estimated that the violence itself (Kaltman & Bonanno, 2003), as well as the suddenness (Boelen, 2015) predict PTSD symptoms. Furthermore, the criminal diligences, missing body and how injured the body looks, the lack of specific information around the incident itself, and overall feelings of shock and denial are likely to be linked to the grief process (Dawson & Riches, 1998; Kristensen et al., 2012), as well as increase the individual's vulnerability to the development of psychopathological symptoms. The very peculiar nature of violent deaths might require that individuals re-experience death-related stimulus (e.g., crime scene, pictures of the scene and/or body, the victim's body (often disfigured)), with this increasing the risk of PTSD and CG symptoms, as described previously (e.g., Boelen et al., 2016; Rheingold et al., 2015; Rheingold et al., 2012). In addition, individuals have to deal with criminal and legal processes (for the first time for the most of them), with this being specifically prevalent among violent deaths. The previous sections summarised how those processes are likely to increase distress, due to the lack of information, uncertainty about the sentences, as well as perceived limited empathic attitudes (e.g., Dawson & Riches, 1998). Furthermore, media coverage is likely, sooner or later, to become part of the individual's lives and perceived as intrusive, unhelpful and linked with additional distress (e.g., Armour, 2002; Dannemiller, 2002).

Regarding the relationship/quality of the relationship between individuals and deceased, both natural and non-natural losses are likely to be the similar, as unsurprisingly closer relationships with lead with greater grief-responses. Mixed findings were described among the few studies with homicidally bereaved individuals, where closer relationships with the victim were linked with greater PTSD and CG responses (Burke et al., 2012; Thompson et al., 1998). However, the age of the victim (children vs. non-children) does not appear to impact on the psychopathology (Asaro, 1992; Grebstein, 1986). On the contrary, when a loss is followed by a homicide (with this being different from 'normal deaths), it might be important to consider the relationship with the offender, especially in cases of dual grief where even more severe psychological difficulties could occur.

Other potential particularities of violent deaths is the described failure of meaning-making about the death. In fact, making sense of a violent loss seems to be more difficult, due to the changed fundamental assumptions about themselves, others and worldviews in general. This is even more complex when the violent loss was a homicide, where a person kill another, leading to feelings of injustice, unfairness and revenge (Currier et al., 2006) and increasing overall distress and traumatic and grief responses.

Finally, the coping patterns described among homicidally bereaved individuals appear to be different when compared with non-violent losses. In fact, studies described an overall difficulty of coping post-homicide. This might happen among non-violent grief processes; however, it is expected that individuals will adjust in approximately 12 months post-loss (Prigerson, 2004). Homicidally bereaved individuals are likely to report maladjustment, ongoing and severe psychopathology symptoms for many years, where physical issues, as well as somatisation are often an outcome as well (as described). This is increasing non-adaptive coping strategies, such as avoidance, drinking and self-medication (e.g., Murphy et al., 1989).

On the other hand, studies have identified positive coping that is likely to help those bereaved by homicide and therefore should be considered in interventions and

research. Those strategies include information about symptoms and legal processes, formal and informal support. Finally, and regarding the individuals' perceptions of informal support, two main conclusions can be made: 1) individuals rely on their family and friends support to better adjust and 2) social awareness about how to respond to grief in general and homicidal grief in particular. Professional support (specifically psychological support) for homicidal bereaved individuals will be explored in chapter 2.

In summary, the reviewed literature increased understanding among homicidally bereaved individuals post-loss, as well as highlighted the main differences between violent and non-violent deaths, in particular following a homicidal death. Empirical-based studies are growing, but nonetheless are still somewhat limited when compared with other forms of violence or trauma expose, such as domestic violence and sexual crimes. Therefore, most of the literature available is cross-sectional in nature, not necessarily providing information about needs over time, as well as dissimilar needs as the time goes by. Furthermore, empirical-based research about what psychological interventions and its effectiveness for those homicidally bereaved is limited. The same is true about specifically UK individuals' experiences with criminal and legal agents. In fact the only study conducted indicates overall encouraging results, with participants reporting high levels of satisfaction with the police officers under research (Cesey, 2011; Mueller-Johson & Lanskey, 2014Wright, 2005). Thus, this should be replicated nationally, as it is likely to informing potential training needs among professionals.

Finally, it is important to note that different cultures hold varying traditions and social norms about grieving (e.g., crying) and it is important not to impose an American/Euro-centric view (Valentine, 2006) of what it is a potential 'normal' reaction to extreme experiences.

Limitations

Despite the usefulness of the present narrative review, its limitations include that it did not adopt a systematic approach allowing for an evaluation of the quality of the literature. However, given the relatively small set of empirical papers in this field, a narrative approach was deemed to be more suitable as a starting point and informed the overall project. However, the conclusions drawn should be interpreted in the context of there being additional work (e.g., unpublished theses, case studies, grey literature) that has not been included or drawn upon herein.

Implications for Research, Practice and Policy

In terms of future research, generalising results from different studies seems to constitute a difficult task, as studies are often not clear about: a) heterogeneity of definitions; b) measurement process and designs; c) controlling for prior experiences (e.g., previous victimisation); and d) controlling for different types of violent death (e.g., homicide, suicide fatal accidents). Therefore, future research should try to address these limitations by:

- Using clear definitions of the individuals under study and seeking to achieve a homogeneity of terms and terminologies across the literature;
- Providing clear evidences of definitions of what causes of death were studied (e.g., homicide, suicide)
- Reflecting on the design adopted (e.g., longitudinal studies, presence of any comparator group) and methodology (e.g., what measures were used).

In terms of practice and policy, it is largely agreed that those bereaved by such traumatic circumstances experience ongoing impact in many areas of their lives (e.g., physical and mental health difficulties, social and financial complications). Therefore, clinicians and practitioners might also benefit from getting involved with existing research groups to facilitate knowledge exchange that will undoubtedly benefit all parties.

Conclusion

The present review highlighted what seem to be the strengths and weaknesses of existing research in the area of traumatic bereavement, and homicidal bereavement specifically. In summary, homicidal bereavement is an example of an extreme traumatic event. Individuals may react and respond thereto over a prolonged period of time as part of the occurrence of traumatic, intense and severe grief processes. They therefore require appropriate and effective support and intervention. It is also important to reflect on how the 'not normal' is defined and measured. For example, the question arises as to whether, after such a traumatic event, psychopathology is actually a functional 'normal' response to an abnormal situation, and when this 'normal' response becomes prolonged and of a dysfunctional nature.

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Chapter 2:

Psychological interventions for homicidally bereaved individuals: a systematic review

Manuscript submitted for publication in *Trauma, Violence, & Abuse*.

Alves-Costa, F., Hamilton-Giachritsis C., Christie, H., van Denderen, M., & Halligan, S. (*in submission*). Psychological interventions for homicidally bereaved individuals: a systematic review. *Trauma, Violence, & Abuse* [August, 2017].

Chapter Rationale

The narrative literature review reported in Chapter 1 revealed that limited empirical studies have been conducted on psychological support for homicidally bereaved individuals. Therefore, a systematic review was undertaken and is presented as Chapter 2 specifically to provide insight into what psychological interventions are mostly 'prescribed' post-homicide, as well as estimate their potential benefits.

This protocol for this systematic review was published via PROSPERO (Appendix I) prior to the searches. In addition, this manuscript has been submitted for publication in *Trauma, Violence & Abuse* and is currently under review.

Statement of Authorship

<table>
<tr><th colspan="10">This declaration concerns the article entitled</th></tr>
<tr><td colspan="10">Psychological interventions for homicidally bereaved individuals: a systematic review.</td></tr>
<tr><td colspan="10">Publication status (tick one)</td></tr>
<tr><td>Draft manuscript</td><td></td><td>Submitted</td><td></td><td>In review</td><td>X</td><td>Accepted</td><td></td><td>Published</td><td></td></tr>
<tr><td>Publications details (reference)</td><td colspan="9">Alves-Costa, F., Hamilton-Giachritsis C., Christie, H., van Denderen, M., & Halligan, S. (in submission). Psychological interventions for homicidally bereaved individuals: a systematic review. Trauma, Violence, & Abuse.</td></tr>
<tr><td rowspan="2">Candidate's contribution to the paper (detailed, and also given as a percentage)</td><td colspan="9"></td></tr>
<tr><td colspan="9">Filipa Alves-Costa made considerable contributions to the conception of the study (50%), as well as the methodological design (70%).The experimental work, including data collection, primary data analysis and interpretation was predominantly conducted by Filipa (90%). Filipa has also established international collaboration (100%, fourth author) with notable researchers in the field.</td></tr>
<tr><td>Statement from Candidate</td><td colspan="9">This paper reports on original research I conducted during the period of my Higher Degree by Research candidature.</td></tr>
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Psychological interventions for homicidally bereaved individuals: a systematic review

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Funding information

This work was supported by Escaping Victimhood and the University of Bath (collaborative scholarship).

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Psychological interventions for homicidally bereaved individuals: a systematic review

Research on death and dying has been undertaken in different disciplines for a number of decades (e.g., psychology, sociology, anthropology), extending knowledge about grief responses and patterns (e.g., Bonanno, Wortman, & Nesse, 2004; Bonnanno & Kaltman, 1999; Klass, Silverman, & Nickman, 1996; Mancini & Bonanno, 2006, Neimeyer, 1997, 2001, 2008; Stroebe & Schut, 1999). Research looking at specific forms of deaths and bereavement (i.e., homicide, suicide, accidents) has also increased in the last few decades (e.g., Amick-McMullan, Kilpatrick,, & Veronen, 1989; Baddeley et al., 2015; Currier, Holland, & Neimeyer, 2006; Parkes, 1993; Rheingold & Williams 2015; Rheingold et al., 2012; Shear, 2012; van Denderen, de Keijser, Kleen, & Boelen, 2014). To date, accumulating evidence suggests that violent (not homicide exclusively) compared to non-violent losses tend to lead to greater and more severe emotional distress, having a significant impact on individuals' lives that experience this kind of losses (Boelen et al., 2015; Boelen, 2015; Kristensen et al., 2012).

In fact, several key elements have been identified as reasons why violent losses are linked with greater distress. The sudden and unexpected, but specifically the violent nature of the deaths seem to be key elements that help to understand the negative outcomes. Some studies have estimated that the violence itself (Kaltman & Bonanno, 2003), as well as the suddenness (Boelen, 2015) are important predictors of PTSD symptoms. Furthermore, factors like the criminal diligences, missing body and how injured the body looks, the lack of specific information around the incident itself, and overall feelings of shock and denial are likely to be linked to the grief process (Dawson & Riches, 1998; Kristensen et al., 2012), and have been suggested to increase the individual's vulnerability to the development of psychopathological symptoms.

Regarding bereavement specifically following homicide, evidence has demonstrated that individuals are likely to face severe psychological and emotional difficulties as a

result, including depression, anxiety, trauma responses/Posttraumatic Stress Disorder (PTSD), and pathological grief (e.g., Armour, 2002; Currier & Neimeyer, 2008; Currier et al., 2006; van Denderen et al., 2014). Those consequences appear to comprise individuals' trajectories where ongoing psychological and physical responses impair individual functioning. In addition, other health consequences are likely to occur. These include sleeping and eating difficulties (Burgess, 1975; Mastrocinque, et al., 2015; Miller, 2009a; Paterson et al., 2006; van Wijk et al., 2017), but also headaches, stomach and bowel complaints, sleeping problems, tiredness, and cardiac complaints (Burgess, 1975; van Wijk et al., 2017). Physical health difficulties also commonly involve shortness of breath, palpitations, restlessness and insomnia (Rheingold et al., 2015). On a personal level, an experience of homicidal bereavement is likely to lead to long-term changes to one's self-perception and role in the wider system and likely to impact on the individual's adjustment as well (Miller, 2009; Rinear, 1988; van Wijk et al., 2017). Those difficulties may affect overall functioning and the individual's ability to work, which might create additional issues for the families (e.g., economic; Wijk et al., 2017). Thus, it is pivotal to understand what psychological interventions are likely to support those individuals.

However, to date, it still remains unclear what psychological interventions are available to support homicidally bereaved individuals over time, and very little is known about the efficacy of such interventions. Thus, few interventions have been developed for adults (e.g., Rheingold et al., 2015; Saindon et al., 2014), or for children and adolescents (e.g., Salloum, 2008; Salloum, Avery, & McClain, 2001) who have been through an experience of homicidal bereavement; those that do exist are mainly from the United States of America. In the UK, some exceptions to this are charities such as Winston's Wish UK (children), Victim Support (Homicide Service; adults), Support after murder and manslaughter (SAMM; adults), and The Moira Fund. These charities offer immediate and helpful support, but models of intervention are unknown and, hence, it is difficult to be clear about adaptations and research-based suggestions/generalisations.

Thus, the aim of this systematic review was to describe the main national and international psychological interventions that are available for individuals who have experienced bereavement through homicide and assess their effectiveness. Specifically, this study aims to address the following questions:

1. What are the main psychological interventions available for homicidally bereaved individuals?,

2. What is the evidence considering the efficacy of the psychological interventions available for homicidally bereaved individuals (e.g., in terms of impact on symptomatology, indicators of well-being and coping mechanisms)?

Method

Search strategy

Core electronic bibliographic databases (APA PsycNET [searches across PsycINFO, PsycEXTRA, PsycTESTS and PsycARTICLES], PubMed, The Cochrane Library [Cochrane Database of Systematic Review] and Web of Science) were searched to identify relevant studies. No restrictions for *grey literature* (e.g., technical or research reports from government agencies and reports from scientific research groups) were put in place; nor for publication year. Searches were conducted in English and performed in November 2016.

An equation combining key words was tested by the first author and approved by the second and fifth authors, as well as by a librarian expert in Psychology and Education. Subjects aiming to identify eligible publications: “Victim” OR “Victims” OR “Co-victim” OR “Co-Victims” OR “Covictim” OR “Covictims” OR “Survivor” OR “Survivors” AND “Homicide” OR “Homicides” OR “Homicidal” OR “Homicidally” OR “Murder” OR “Murders” OR “Wrongful Death” OR “Wrongful Deaths” OR “Killing” OR “Killings” OR “Manslaughter” AND “Traumatic Bereavement” OR “Traumatic Grief” OR “Mourning” OR "Mournings" OR “Traumatic loss” OR “Traumatic losses”. Relatively broad search

terms were used to increase the chances of finding eligible studies. In addition, reference sections of included studies and existing reviews were screened, books were manually searched and Google Scholar was used. Finally, national and international authors/researchers were contacted by email. This request sought to obtain any suggestions of potential eligible studies, due to their expertise and experience.

The systematic review protocol was published via PROSPERO (Appendix J) prior to searches (September 2016; amended November 2016 to include co-author, plus clarification of inclusion criteria for mixed sample studies). The final search was performed in May 2017, with no further papers identified. Although no date restrictions were put in place, all included records were published between 2001 and 2015 in peer-reviewed journals.

Inclusion/exclusion criteria

This review focused on homicidal bereavement, rather than death/loss described as 'violent' or 'traumatic', which might refer to different causes of deaths (e.g., suicide, wars, terrorism acts) that have different outcomes. The PECO (population, exposure, comparison, and outcome of interest) framework used was: *P:* homicidal bereaved individuals; *E:* psychological and emotional outcomes; *C:* pre and post-treatment measurements; *O*: effectiveness of psychological interventions. Studies were included if they: 1) examined psychological interventions following an experience of homicidal bereavement (murder or manslaughter); 2) at least 50% of the participants were homicidally bereaved, in case of mixed samples of violent losses (e.g., suicide, accident); 3) included family members or other close relatives with the person who died (e.g., adoptive family, close friend); 4) included quantitative validated measures and/or qualitative interviews; 5) had a pre post-treatment comparison or control group; and 6) were written in English. Exclusion criteria were: 1) study did not consider specific mental, social health intervention and/or outcomes; 2) qualitative studies; 3) lack of validated

outcome measure; 4) absence of control group or post intervention comparison; and 5) lack of information about percentage of sample that is homicidally bereaved.

Study selection

A Preferred Reporting Items for Systematic Reviews and Meta-Analyses (Moher et al., 2009) PRISMA diagram was used to describe the systematic review process. The initial search generated 127 articles. An additional 23 records were identified through other sources (paper reference lists, books). When studies with unclear mixed samples (e.g., violent loss, violent deaths) and/or that were imprecise about the exact number of homicidally bereaved individuals included in their samples, authors were contacted by email in order to check their eligibility.

After removing 42 duplicates, titles and abstracts of 108 records were screened, of which 77 articles were identified for full-text reading and assessed for eligibility. Overall, 72 records were excluded. The majority of records were excluded because their sample comprised predominantly other traumatically bereaved individuals (e.g., suicides, car accidents) and not necessarily homicide, as well as an absence of control group or post intervention comparison. Six articles met the inclusion criteria and were included in the review; five via the searches, the other was one of two additional papers suggested by contacted researchers. These studies were conducted in the United States (N = 5) and Japan (N = 1) between 2001 and 2015.

For reliability, a second independent screen of 19 records was completed by the third author. Results from *Cohen's K* test indicated a substantial level of agreement (k = .759, p = .001). The second reviewer initially included two additional papers, but these were based on traumatic bereavement; hence, the final decision was to exclude.

Quality assessment

All studies underwent a risk of bias assessment using the Hawker's Checklist (Hawker, 2002; supplementary table), given that the Cochrane tool is primarily used for measuring risk of bias in randomised control trials. This checklist include a five-point

Likert scale (from poor quality to good) for each type of bias plus a total score (generated by summing the individual scores by each study out of a possible 36). The measurement of quality was performed by the same two reviewers to ensure reliability. Results from Cronbach's alpha test indicated a substantial level of agreement (Cronbach's alpha =.909, p = .020). The included records demonstrated good quality overall, as scores ranged between 26 and 33 points (see Table 1 for scoring for each study).

Table 1. Quality assessment based on Hawker, et al. checklist (2002).

	Asukai, Tsuruta, & Saito (2011)	**Rheingold, Baddeley, Williams, Brown, Wallace, Correa, & Rynearson (2015)**	**Saindon, Rheingold, Baddeley, Wallace, Brown, & Rynearson (2014)**	**Salloum (2008)**	**Salloum, Avery, & McClain (2001)**	**Tuck, Baliko, Schubert, & Anderson (2012)**
Criteria						
Abstract and title	4	4	3	4	3	3
Introduction/ aims	3	4	4	4	4	4
Method and data	4	4	3	4	4	2
Sampling	3	3	3	3	4	3
Data analysis	3	4	4	4	4	3
Ethics and bias	4	3	3	3	1	3
Results	2	4	3	4	4	3
Transferability or generalizability	2	3	3	3	3	2
Implications and usefulness	4	4	4	4	4	3
Total Score (%)	29 (80.5)	33 (91.6)	30 (83.3)	33 (91.6)	31 (86.1)	26 (72.2)

Legend: Good = 4; Fair = 3; Poor = 2; Very poor = 1; Lower scores = poor quality (Max = 36**)**.

Results

Details of the included studies will be synthesised, followed by consideration of their findings (Table 2 summarizes the methodology by record).

Table 2. Included papers: methodology.

Study Country	Total N (n Homicide)	Recruitment	Type of study	Design	Measures
			Adults		
Asukai, et al., 2011 (Japan)	13(7)	Individuals were referred by clinics, counselling centres and victim support services	Exploratory longitudinal study	Repeated measures (pre, post-intervention and 3-, 6-, and 12-month follow-ups)	PTSD on the Clinician-Administered; PTSD Scale for DSM-IV; Complicated Grief[1]; Impact of Event Scale-Revised (IES-R)[2]; Center for Epidemiologic Studies Depression Scale[3]
Rheingold, et al., 2015 (USA)	91(62)	Counselling seeking participants for bereavement related issues were recruited at a medical centre between 2001 and 2011	Open trial (community sample)	Repeated measures (pre and post-intervention and 12-month follow-ups)	Demographics/loss characteristics; Relationship quality; Complicated grief - CGA-SR[4;] Beck Depression; Inventory[5]; Impact of events scale-revised[6]; Death Imagery Scale[7]
Saindon, et al., 2014 (USA)	51(41)	Participants were recruited at a medical centre between 1998 and 2011, as they were seeking counselling support due to bereavement issues.	Open Clinical Trial	Repeated measures (pre and post intervention)	Beck Depression Inventory[8]; Impact of Events Scale[9]; Inventory of Traumatic Grief[10]; Demographics and loss characteristics;

Tuck, et al., 2012 (USA)	8 (8)	Advertisements placed in local social centre and media, word-of-mouth referrals	Exploratory longitudinal study	Repeated-measures (5 time points: 28hr post treatment, 6, 12 weeks, and 30 months post intervention)	General Well-Being Scale[11]; Center for Epidemiological Studies Depression Scale[3]; IES-R[12]; PTSD Checklist–Civilian Version[13]; The Texas Revised Inventory of Grief[14]; Spiritual Well-Being Scale[15]; Herth Hope Index[16];Trait Forgivingness Scale[17];Transgression-Related Interpersonal[18]; Motivations Inventory[19]; Single-Item Forgiveness Scale[20]; Religious Coping Scale[21];
		Children			
Salloum, 2007 (USA)	89 (21 groups)	Secondary analysis using data from children who participated between 1997 and 2001 in the Project LAST, a grief and trauma intervention	Community-based grief and trauma therapy	Repeated measures (pre and post-intervention)	Child Posttraumatic Stress Reaction Index[22]
Salloum, et al., 2001 (USA)	45(45)	Secondary analysis using data from youths (LAST, a grief and trauma intervention)	Community-based grief and trauma therapy	Repeated measures (pre and post-intervention)	Child Posttraumatic Stress Reaction Index[22]

1.Prigerson et al., 1995; 2 Weiss, 2004; 3. Radloff, 1977; 4. Based on Prigerson et al., 1995; 5. Ward, Mendelson, Mock, & Erbaugh, 1961; 6. Weiss & Marmar, 1997; 7. Rynearson & Correa, 2008; 8. Ward, Mendelson, Mock, & Erbaugh, 1961; 9. Wilner, & Alvarez, 1979; Weiss & Marmar, 1996; 10. Prigerson et al., 1995; 11. Dupuy, 1978; 12. Eaton, et al., 2004; 13. Weathers, Litz, Herman, Huska, & Keane, 1993; 14. Faschingbauer, 198; 15. Paloutzian & Ellison, 1982; 16. Herth, 1992; 17. Berry, Worthington, Parrott, O'Connor, &

Wade, 2005; 18. McCullough, 1998; 19. Berry and Worthington, 2001; 20. Pargament et al., 1997. 21. Frederick, Pynoos & Nader, 1992; 22. Pynoos et al., 1987.

Data synthesis

Design of studies. The reviewed studies included two designs: exploratory intervention studies (N=4) and open clinical trials (N=2). All studies performed quantitative repeated measures with a variable length of time between comparisons: all considered pre-post assessments, one had one follow up data point and two had three follow up data points.

Aims of studies. All the studies aimed to evaluate the effect of a specific psychological treatment following a 'traumatic' or 'violent' death. Three studies included mixed samples (homicide, suicide, motor vehicle accident and other accidents), albeit with a majority of homicidally bereaved. In addition, studies sought to test the feasibility of offering novel interventions (i.e., Restorative Telling (RT), TOZI Healing Retreat© and CBT grief and trauma interventions). Finally, studies also aimed to understand how other variables (e.g., age, time since loss, relationship with the person who died) are likely to impact post-intervention outcomes and progress.

Psycho-emotional variables and measurement. Analyses of psychological and emotional outcomes as indicators of intervention effectiveness included post-traumatic stress disorder (PTSD), grief responses, complicated grief (CG) and depression. Some studies also looked at individuals' general wellbeing, as well as religious coping, forgiveness and hopelessness. All of the included studies included demographic information of the participants, as well as heath and loss history (albeit with differences in level of detail; see table 2 for more detail).

Samples. Samples were generally small and/or had high attrition at follow-up (pre-intervention range: 8-114; at end point: 7-89). In four studies, participants were over the age of 18 years (Means 45-52 years old; Asukai, Tsuruta, & Saito; 2011; Rheingold et al., 2015; Saindon, Rheingold, Baddeley, Wallace, Brown, & Rynearson, 2014; Tuck, Baliko,

Schubert, & Anderson, 2012); the other two had child samples (Means 8-14 years; Salloum, 2008; Salloum, Avery, & McClain, 2001). A majority of samples were: a) female, b) classified as African-American with low-to-medium incomes (or family incomes for the children and adolescents' studies), and c) college educated. Only one study reported clinical/health information (no history of psychiatric illness or substance abuse prior to the loss) and details of post-homicide support (Asukai et al., 2011; see Table 3 for more details).

Mean time since the homicides ranged from one week (in a case of two participants < 18 years old) to 28 years. Most of the individuals had lost a child (either in childhood or adulthood), although other relatives were also reported, such as romantic partner, sibling or other relatives). Children and adolescents were more likely to have lost a family member (e.g., parent, uncle or aunt, cousin), as well as friends. Only one study (Tuck, et al., 2012) reported the participant's relationship with the perpetrator, classified as a stranger by six of eight individuals. Furthermore, several individuals reported having witnessed the homicide, saw scene of death or the aftermath of the homicide (i.e., 44 children out of 102 – 43%; 9 adults out of 89 (10%) and 19 adults out of 51, 37%; Salloum, 2008; Rheingold, et al., 2015; Saindon, et al., 2014, respectively).

The included studies adopted different recruitment strategies with participants referred/recruited: by clinics, medical centres, counselling victim support services (Asukai, et al., 2011; Rheingold et al., 2015; Saindon et al., 2014), in the community via advertisements placed in a local social centre and media, as well as word-of-mouth referrals (Tuck, et al., 2012), or the paper reported secondary analyses using data from children who participated in the Project LAST (Salloum, 2008; Salloum, et al., 2001).

Table 3. Sample characteristics.

Authors (Year)	**Gender**	**Mean age (SD)**	**Background**	**Marital Status**	**Education**	**Occupation**	**Income (per household/per year)**
Asukai, et al., 2011	F=13	45.15 (SD = 9.81)	Japanese	Majority married	High school (n = 5) Vocational school (n = 5) college (n =4) Junior high school (n = 1)	6 employed; 9 homemakers	-
Rheingold, et al., 2015	F=63 M=21	45.34 (SD = 12.71)	European-American (n = 71) Africa-Americans (n = 3) Hispanics (n = 2) Other (n = 5)	n/a	College educated (n = 55)	-	-

Authors (Year)	**Gender**	**Mean age**	**Background**	**Marital Status**	**Education**	**Occupation**	**Family Income (per household; per**

		(SD)					**year)**
Tuck, et al., 2012	F=7 M=1	52.2 (SD = 8.8)	African-American (n = 6) Caucasian (n = 2)	*Baseline* Married (n = 4 out of 8) *Follow-up* Divorced (n = 1)	College (n = 7) Enrolled in college (at that time; n = 1)	Full time employed (n = 2) Part-time employed (n = 2) Unemployed (n = 1) Disability (n = 1) Retired (n = 1)	> US$31,000 (n = 6)
Salloum, 2007	F=53 M=49	8.83 (SD = 1.77)	African-American (urban)	-	Attending the first through the third grade (n = 52) Attending the fourth through the sixth grade (n = 50)	-	< less $10,000 (n = 61) $10,001- $24,999 (n = 5) $35,000-$49,999 (n = 1)
Salloum, et al., 2001	F= 27 M= 18	14.3	African-American	-	-	-	<$10,000 (estimated)

Intervention models. All of the studies conducted group interventions with the group size ranging from six to 13, but different interventions were used. Duration and frequency varied from a two-day holistic retreat, 8, 10 or 15 weekly sessions (90 minutes) or 10 two-hour weekly sessions. Models of interventions included: cognitive behavioural therapy (CBT), restorative retelling intervention (RR); residential psychoeducational retreat and CBT interventions together with psychoeducational elements.

A CBT intervention focusing on trauma and grief responses was used in one study (Asukai, et al., 2011). This intervention was based on Shear's model (an eclectic grief therapy with modified techniques of prolonged and imaginal exposure (PE) for PTSD; see Foa, Hembree, & Rothbaum, 2007), but with the restoration-focused component (motivational enhancement therapy) eliminated.

Restorative Retelling (RR; Rynearson, 2001; Rynearson, Correa, Favell, Saindon, & Prigerson, 2006) was adopted in two studies (Rheingold et al., 2015; Saindon et al., 2014). The intervention include core elements such as: resilience, trauma responses, commemoration of the life of the deceased through sharing of positive memories, and relaxation training. The two-day *Residential psychoeducational retreat* (Tuck et al., 2012) followed a holistic framework philosophy where mind, body and spirit are seen as pivotal characteristics to improve wellbeing using a psychoeducational model focusing on trauma, complicated grief and judicial processes. Techniques included narrative storytelling, journals about loss, mediation and guided imagery.

The studies with children and adolescents used a *CBT intervention* and *psychoeducation* (Salloum, 2008; Salloum, et al., 2001). The sessions were based on 14 main themes: pre homicide experiences, PTSD, grief, family, safety, memories, spirituality, feelings, anger management, coping strategies, future and post-PTSD, using developmentally appropriate strategies (e.g., play, drama, discussion, drawing, storytelling, and writing).

Effectiveness of the interventions

Overall, results were encouraging (effect sizes ranging from small to large; Table 4). With group *CBT* (Asukai, et al., 2011), there were large effect sizes pre to post-intervention (5 time points; Cohen's *d* ranged from 0.99 to 1.97). Furthermore, symptom levels remained low post-treatment to 12-month follow-up for complicated grief, intrusion, avoidance, hyperarousal symptoms and depression; whilst 84.6% (11 of 13) no longer met PTSD criteria.

Data from the two *RT interventions* (Rheingold et al., 2015; Saindon et al., 2014) demonstrate an overall positive effect on wellbeing with small to medium effect sizes (Cohen's *d* ranged from 0.20 to 0.50). Indeed, Rheingold et al. (2015) reported significant interaction effects over time on depression symptoms (*d* = .44), overall PTSD symptoms (*d* = .46); intrusions symptoms (*d* = .44); hyperarousal (*d* = .42), and avoidance symptoms (*d* = .33). Additionally, overall thoughts and death images decreased significantly (.31). However, complicated grief symptoms did not change significantly. Follow-up assessment also demonstrated significant improvements from pre to post treatment and 12 months follow-up on depressive symptoms, PTSD and complicated grief with large effect sizes (Cohen's *d* ranged from .97 to 1.21). Notably, homicidally bereaved individuals demonstrated greater overall PTSD symptoms in comparison with individuals grieving following suicides and/or accidents (p = .028), as well as avoidance, (p = 024) and hyperarousal symptoms (p = .016).

Similarly, Saindon et al. (2014) found a significant reduction of symptoms from pre to post-treatment for depression, intrusion and traumatic grief symptoms (small to large effect sizes; η^2 from .04 to .35), but not for avoidance. Furthermore, individuals with more severe baseline symptoms had greater symptom reduction over time. There was an effect on depressive, avoidance and traumatic grief symptoms with small to medium effect sizes (η^2 from .12 to .25) and marginally significant effect on intrusion symptoms (η^2 10).

In the two-day *weekend retreat intervention* (Tuck et al., 2102), an overall positive effect of the intervention was reported: changes were found in the participants' scores on general welling, spiritual wellbeing, PTSD grief, forgiveness, hopefulness, and religious coping. Depression scores tended to increase immediately following the intervention, decreasing slightly at the 6-weeks follow up, but increasing again at 12-months follow-up. Furthermore, hyperarousal, intrusion and avoidance responses to traumatic events also changed in a positive direction, as did grief responses scores showing better grief resolution. Furthermore, individuals seemed to have reported a more positive attitude on the post-intervention, with increased interpersonal motivations to forgive, lower negative coping and increased hopefulness.

Findings from the *CBT grief and trauma intervention* with children (Salloum, 2008) demonstrated a significant decrease in posttraumatic stress scores from pre to post-test with large effect sizes (Cohen's *d* ranged from .34 to .45) on avoidance (d = .45), re-experiencing (d =.38) and, arousal (d =.34). However, having witnessed the event or not was significant in both rates of pre-intervention scores (witnesses had more severe symptoms), but also on the effect of the intervention effect: children who did not witness the event/aftermath experienced the largest treatment effect (d = .68) compared to child witnesses (d = .14). Results of this intervention with teenagers (Salloum, et al., 2001) demonstrate that participants improved PTSD symptoms from pre to post-intervention (p=.001). In addition to the total scores, *re-experiencing* and *avoidance* clusters were significantly different at pre and post-intervention (ps $\leq$ .003), but *arousal* was not (p = .114).

Table 4. Main findings by record.

Authors	Intervention Design	Psychopathology assessed	Data analyses	Main findings
		Adults		
Asukai, et al., 2001	15 weekly (90-minute); CBT approach Traumatic Grief Treatment (adapted Shear's model) including: 1) psychoeducation, 2) rationale for the use of exposure therapy and 3) intensive imaginal exposure activities	PTSD and traumatic outcomes Grief Depression	Repeated measures ANOVA with Tukey's studentized range tests for comparison of pairs of means Within-group effect sizes of Cohen's d pre- and post-treatment	Statistical significant reductions of symptoms (***baseline to 12 months follow-up***) on complicated grief, intrusion, avoidance, hyperarousal, depression (p values < .001) Criteria for PTSD was not met at 12 months follow-up by 84.6% of the participants (*n* = 11)
Rheingold et al., 2015	Restorative Retelling (RR) 10-session weekly (2-hour) group therapy. 1) psychoeducation - resilience and stress reduction techniques, 2) commemorative imagery, and 3) death imagery	Depression PTSD Complicated Grief	Mixed-model repeated measures ANOVAs to examine differences over time Mixed-model regression analyses were also used to test the effects of factors (relationship quality and time since loss)	***Pre and post treatment:*** significant effect on depression, PTSD ***At 12-months follow-up***: significantly lower depression, PTSD, CG. Time since loss did not impact. Reduction of CG for women. Better quality of relationship with deceased: higher post-treatment CG/PTSD; losing a child: showed greater decreases in avoidance. Homicidally

				bereaved> PTSD, avoidance & hyperarousal than suicide/accident
Authors	**Intervention Design**	**Elements assessed**	**Data analyses**	**Main findings**
Saindon et al., 2014	Restorative Retelling (Rynearson, 1998, 2001) 10-session weekly (1.5-hour) group therapy. 1) psychoeducation - resilience and stress reduction techniques, 2) commemorative imagery and positive memories, and 3) death imagery	Tolerance to the intervention; Depression Avoidance; Intrusion CG	Mixed-model repeated measures ANOVAs were conducted to examine overtime differences on the domains tested	***Pre to Post-treatment assessments***: Decreased depression, intrusion and traumatic grief symptoms (but not on avoidance symptoms) Severe symptoms at baseline had an effect on depressive, avoidance, traumatic grief symptoms and a marginally significant effect on intrusion symptoms

Tuck et al., 2012	TOZI Healing Retreat; 2 days Holistic retreat (sessions 45-90 min). 1) psychoeducational elements (e.g., CG and judicial system, stigma); 2) guided imagery exercises; reflection, mindfulness and narrative storytelling	General wellbeing; PTDS; depression; grief; religious coping; forgiveness	Descriptive statistics were used to provide an overview of the measures on the 5 time points, as well as to describe post-intervention outcomes Spearman's Rho correlations of paired scores to test family patterns	Improvement on main domains: general & spiritual wellbeing, PTSD, grief, forgiveness, hopefulness, religious coping; exception of depression. Baseline (T1) and 30 months follow-up (T5) *General wellbeing*: 56.75 to 67.21 *Spiritual Wellbeing:* 100.63 to 104.71 *Grief responses*: 59 to 64.43 *Motivation to forgive*: 37.13 to 33 *Religious positive coping*: increased over time and only returning to baseline at T5; *Religious* negative coping: declined over time and remained below the baseline score

Children

Authors	Intervention Design	Elements assessed	Data analyses	Main findings
Salloum, 2007	Grief and trauma model intervention: school-based group intervention 8 to 10 sessions covering 14 possible themes (e.g., PTSD, grief education, safe places, memory, emotions, and coping strategies)	PTSD (re-experiencing, avoidance, and arousal)	*T tests* and ANCOVAs were used to calculate pre and post-treatment	***Pre and post-treatment assessments***: Significant decrease in posttraumatic stress. No statistically significant mean difference in post-test between younger children and older children. Older children scored slightly lower than younger children on the posttraumatic stress post-test
Salloum et al., 2001	Grief and trauma model intervention: school-based group intervention (e.g., PTSD, grief education, safe places, memory, emotions, and coping strategies)	PTSD (re-experiencing, avoidance, and arousal)	Linear regression model was used to calculate the effect of time on pre and post-intervention scores; *T tests* were used to calculate pre and post-treatment	***Pre and post-interventions***: PTSD scores decreased significantly. There were no differences between genders Length of time since the event did not impact pre and post-interventions scores

Potential mediating variables

Only three studies considered any form of mediating factors, including closeness and quality of the relationship with the victim.

Gender. This was considered as a factor in three studies (two with children). The studies with younger people found no statistically significant mean gender difference in post-test CPTS-RI scores (p = .645; Salloum, 2008) or on PTSD pre-post (p=.355; Salloum et al., 2001). However, with adults, Rheingold et al. (2015) noted a significant gender interaction with complicated grief symptoms over time (pre-post treatment; p=004). Follow-up pairwise comparisons revealed reduced complicated grief symptoms for women (p=.003), but not men.

Age. There were no statistically significant mean differences in post-test CPTS-RI scores between younger and older children (p = .218; Salloum, 2008). However, older children scored slightly lower (1.17 points) than younger children at post intervention for posttraumatic stress. However, there was an interaction effect of gender and developmental status with post-test CPTS-RI scores, (p = .032) with older girls demonstrating a great adjustment on the posttraumatic stress post-test (p = .022), accounting for 5.3% (partial $\eta 2$ = .053) of the variance post-intervention.

Relationship proximity and quality. Only two studies have considered the relationship with victim (Asukai et al., 2011; Rheingold et al., 2015), identifying that more positive relationships with the deceased were associated with greater post-treatment symptom severity in terms of complicated grief (p =.033; 95% confidence interval [CI]= 0.09, 1.89), PTSD (p=.025, 95% CI=0.21, 2.99) and hyperarousal (p=.018, 95% CI=0.11, 1.12). Quality of the relationship did not predict intrusive thoughts, avoidance nor depression. There were no interaction effects of time (pre and post-treatment) by type of relationship (child vs no child) for depression, complicated grief, PTSD, intrusions or arousal (minimum p > .05). In contrast, the relationship to the deceased did not impact the

treatment efficacy (*d* = 1.72; Asukai, et al., 2011), where mothers who had lost a child showed as much improvement as those with the loss of other loved ones.

Time since loss. None of the three studies that examined the relation between time since loss and treatment outcome i.e., intrusions, avoidance, hyperarousal, complicated grief (Rheingold et al., 2015), or PTSD found any effect (Rheingold et al., 2015; Salloum et al., 2001; Salloum, 2008).

Type of death. Rheingold et al. (2015) found no significant interaction effects of time (pre- and post-intervention) by type of death for all the symptoms assessed (depression symptoms, overall PTSD symptoms, intrusions, avoidance, hyperarousal, or complicated grief symptoms). However, statistically significant effects for type of death emerged across time: homicidally bereaved individuals had higher PTSD symptoms (p=.028), avoidance (p=.024) and hyperarousal (p=.016) compared with those grieving following suicide or accident.

Witnesses vs. Non-witnesses. Salloum (2008) found that children who witnessed the homicide and/or aftermath reported initially higher levels of posttraumatic symptoms; 41% (n=15) of those children who remained in the clinical range of symptoms on the post-treatment. However, there was no statistically significant results between pre- and post-test, and proximity (witness and non-witness).

Discussion

To the best of our knowledge, this review is the first to systematically identify the psychological interventions available for individuals following homicidal bereavement and consider their effectiveness. Most notably, the lack of specifically adapted interventions and available evaluations was apparent. The small number of studies included in this review demonstrates that limited evidence-based research has been conducted. Furthermore, the search found evidence that some studies have looked at experiences of traumatic bereavement, but not necessarily following a homicide and/or did not describe their samples characteristics with clarity (i.e., total number of participants bereaved by different causes of death). Additionally, not many studies have considered the use of control groups or repeated measures designs, for instance. Although the quality of the studies was generally rated as good (i.e., ranging from 26 to 33 points out of 36; over 72.2%) the conclusions should be carefully interpreted, due to the limited available evidence. Appropriate conclusions and reflections will be summarised below.

As noted, there are limited studies evaluating interventions. From the searches conducted, group (for adults, children and adolescents) structured intervention models combining different approaches and techniques seem to be the preferred method. Those group interventions mainly include psychoeducational elements, coping skills, relaxation training, and emotional support for those bereaved in traumatic circumstances, as well as exposure and death imagery. It is believed individuals can gain from contact with others that have been through similar experiences (Lexius et al., 1992). Therefore, group interventions seem to be an adequate intervention setting for those bereaved by homicide.

Encouraging results were found about the efficacy of the treatments at reducing psychopathology at post-intervention using CBT, RR with psychoeducational, trauma and grief elements. Further, interventions were effective immediately after the intervention, and results maintained at follow-ups for the main intervention outcomes (i.e., PTSD, depression and complicated grief). It is important to note that PTSD symptoms were

assessed for different age groups (i.e., adults, adolescents and children). However, results from pre- to post-intervention were identical (Salloum, 2008; Salloum, et al., 2001). Finally, three studies did not follow-up the individuals post-intervention (Saindon et al., 2014; Salloum, 2008; Salloum, et al., 2001). Therefore, it was not possible to identify psychopathology trajectories longitudinally, as it was for the remaining three studies (Asukai et al., 2011; Rheingold, 2015; Tuck, 2012).

Additionally, not all the included records have considered variables that are likely to impact on the intervention outcomes (e.g., time since loss, relationship with the victim, offender and, pre-victimisation experiences). Overall, mixed findings were found about the role of gender, relationship/proximity with the victim, time since loss and type of death. Despite the overall small sample sizes, dissimilar variables controlled by each study, as well as the small sample size of this systematic review results might add some insight.

Gender of children and adolescents did not impact on the PTSD symptoms progress (Salloum, 2008; Salloum et al., 2001). On the contrary, male and females responded differently on complicated grief symptoms: women reported a greater reduction of CG symptoms over time (Rheingold et al., 2015). This might highlight the need for further research, in order to understand if there are gender differences for symptoms progression over time, as well as engagement to treatment. Regarding the *age* of the participants, Salloum (2008; the only study that considered this variable) found that there were no statistically significant mean differences between younger children and older children on the PTSD responses.

Perhaps unsurprisingly, the *relationship/proximity with the person who died* (included in the analyses of two studies; Asukai, et al., 2011; Rheingold et al., 2015) seemed to be an important predictor of poorer adjustment. More positive relationships with the victim were associated with greater symptom severity in terms of complicated grief, as well as hyperarousal symptoms post-treatment. Interestingly, there were no interaction effects of time (pre and post-treatment assessments) by type of relationship with the

deceased (child vs no child). Parents that have lost a child became less avoidant compared to those who lost another type of loved one, but that might reflect an initially higher level of avoidance. This seems to be unclear in the literature and future research should aim to better understand if this variable impacts on the treatment outcome.

Furthermore, *time since loss* did not impact on the interventions effects (Rheingold et al., 2015; Salloum et al., 2001, 2008) suggesting that there are other factors that lead an individual to a more complicated response and that such a response does not necessarily just reduce with time. Hence, this highlights the need to identify individuals with complicated grief responses and psychological distress that are likely to continue over time and therefore require additional support. Previous (more general bereavement) research has demonstrated that time frequently does not alleviate the issues associated with the maladaptive responses to the loss (e.g., Lichtenthal et al., 2004). Further and as a research note, it also highlights the importance of timing of recruitment when interviewing bereaved individuals (Currier et al., 2008).

Finally, homicidally bereaved participates (when compared with other traumatic grief experiences) demonstrated greater overall PTSD symptoms (Rheingold et al., 2015). Unsurprisingly, *witnessing the* homicide *event and/or aftermath* (element controlled in one study) seemed to impact PTSD symptoms (remained in the clinical range post-treatment; Salloum, 2008). With this highlighting the need of potential prolonged support.

This systematic review suggests that both CBT and RR with psychoeducational, grief and traumatic elements seem to be effective to support homicidally bereaved individuals. However, this study was not able to identify what components of treatment are crucial or expendable (e.g., psychoeducation, exposure, emotional expression, cognitive or meaning-oriented interventions, coping, resilience and positive change/growth). This is something that future research should consider, as was also noted by Currier et al. (2008), but also to apply a theoretical basis for the potential outcomes. For example, research on meaning-making seems to suggest that violent deaths (not only homicides) are likely to

impact on the individual's ability to fully 'process' their experience, with this causing greater distress and maladjustment (e.g., Jordan & Neimeyer, 2003). Furthermore, homicides (very often) involve acts of violence and torture that might activate individual's sensory memories of the loss experience regardless of whether the individual was present at the death scene (Rynearson, 2001). Therefore, it might be important to identify what traumatic narratives individuals have and see if they can be modified/understood in therapeutic settings, as is highlighted in PTSD models (Ehlers & Clark, 2000).

At a broad level, the ongoing criminal justice system processes and media intrusion might be impacting on the individual's grief journeys/symptomatology (e.g., *names removed for masked review, in submission*), and should be factored in when designing clinical interventions. Therefore, it is important to understand the most favourable timing for the intervention be delivered (short vs long-term interventions vs. short-term interventions delivered in key specific times). Finally, other treatments for homicidally bereaved individuals (and other violent deaths) seem to be gaining importance. For example, a combined therapy, consisting of EMDR (Eye Movement Desensitisation and Reprocessing) and CBT for adult homicidally bereaved individuals was delivered and tested by van Denderen, de Keijser, Stewart, & Boelen (submitted) and results should be available in the near future. Similarly, evidence-based research conducted by Layne and his team (e.g., 2014, 2015), as well as an exhaustive review (Layne, et al. submitted) is likely to contribute to an overall understanding of traumatic bereavement among children and adolescents.

Strengths and limitations of this review

To the best of our knowledge, this study is the first review to systematically consider the effectiveness of interventions for homicidally bereaved individuals. Therefore, this can lead to ideas for research, clinical and policy-making in the future (see Table 5). The number of included studies (six) might be seen as a potential limitation, as it only offers a limited view about the phenomenon. On the other hand, this small number might

also reflect some of the limitations found. Despite the increased empirical research about traumatic/violent deaths (including homicide), there are some uncertainties still, especially about what psychological interventions might be the most appropriate and effective to prescribe following such experience.

The literature lacks clarity defining what type of deaths individuals have been through. Indeed, different causes of deaths seem to appear mixed all together under 'general labels', such as 'traumatic and violent deaths'. When mixed samples are used, individual rates by causes of deaths are not always provided. Therefore, this systematic review only included publications with ≥ 50% of homicidally bereaved individuals, as it was aimed to look at those experiences in particular. However, samples were small, only some included control groups and most of the research-based results are driven from clinical open trials. Only studies from the USA and Japan, and papers written in English were included. Therefore, general conclusions and generalisations to the wider population need to be carefully made. In fact, very little is known about possible cultural differences and treatment efficacy. Furthermore, the main focus was on individual violence, therefore homicides committed in the context of collective violence (e.g., terrorist attacks, wars) were not considered, as it is not clear if the collective aspect of the grief experiences impact on the outcomes. Other research (e.g., Layne et al., 2001; Rock, 1998, Neimeyer, 2008, 2010; Rynearson, 1994, 2006) was excluded from this review as it did not meet the inclusion criteria, yet the work developed by those authors provides very useful general information about homicidal bereavement.

Future research would benefit from including clear terminology and methodology, as well as control groups comparisons to better estimate interventions efficacy. Mixed methods approaches (with both quantitative and qualitative elements) could increase knowledge regarding the individuals' practice and intervention needs. Furthermore, longitudinal studies with longer follow-up periods could better estimate the individual's trajectories of (Mal)adjustment. Finally, studies could also consider adjustment indicators,

such as coping resources and resilience, as it might offer pivotal information for treatment efficacy.

Table 5. Implications for Research, Practice and Policy.

Implications for Research	Implications for Practice and Policy
• Homogenous terminology and samples. Mixed samples (when used) should be clear described (N and percentages of the different causes). • Validated instruments and clinical interviews based on DSM-V (or equivalent instruments) to assess disorders/psychopathology. • More research among individuals who did not seek treatment is needed. • Adjustment outcomes (rather than only impairments) such as coping resources and resilience trajectories might offer pivotal information for treatment efficacy. • Other variables should be more often considered: relationship with the victim and offender, support received since the homicide (i.e., psychological and/or drug based treatments), other traumatic events pre-homicide, time since loss, mental/emotional/physical issues pre-homicide. • Mixed methods and longitudinal approaches and cost–benefit analyses. • Replicable psychological interventions (e.g., national and international comparisons).	• Considering the cause of deaths may be an important variable when conducting interventions (particularly group interventions). • Conducting extensive and detailed anamnesis with the individuals may offer alternative views about the experience of homicidal bereavement, as well as promote more effective psychological interventions. • Making the academic/clinical knowledge available for the public domain might increase social awareness and empathy. • Providing specialised training for those who work with homicidally bereaved individuals. • Developing awareness among policy-makers about the importance of offering (specific) psychological interventions for those individuals. • Clinicians and practitioners might benefit from getting involved with existing research groups in order to facilitate knowledge exchange that will undoubtedly benefit all parties

Conclusion

In conclusion, on the basis of this review, psychological interventions (CBT, RR and psychoeducational models with grief and trauma elements) appear to be beneficial for homicidally bereaved individuals in terms of decreasing psychopathology symptoms and increasing overall wellbeing (Table 6 summarizes the key conclusions of the systematic review).

Nevertheless, generalisations cannot be made, due to the limited evidence-based research. Furthermore, it remains unclear why some individuals have more severe grief reactions than others and require additional support. Indeed, it would be important to explore whether, after such a traumatic event, psychopathology is actually a functional 'normal' response to an abnormal situation, and when this 'normal' response becomes prolonged and of a dysfunctional nature. On the other hand, it also remains unclear what domains are crucial to be included in psychological interventions. Therefore, it is pivotal to increase evidence-based treatments (practice and rigour) in order to produce more solid conclusions in the future. In terms of practice and policy, it is largely agreed that those bereaved by such traumatic circumstances experience ongoing impact in many areas of their lives (e.g., physical and mental difficulties, social and financial complications). Therefore, clinicians and practitioners might also benefit from getting involved with existing research groups in order to facilitate knowledge exchange that will undoubtedly benefit all parties.

Table 6. Key points of the systematic review.

- This review suggests that homicidal bereaved individuals benefit from psychological intervention post-homicide. PTSD, depression and complicated grief (the main treatment outcomes measured) decreased over time.
- The psychological intervention models used were CBT, RR and, Psychoeducational. However this systematic review is under-powered to provide insights about what psychological models are likely to be 'more effective'.
- Included studies differ in sample size, research designs and outcomes measured. Dissimilar characteristics were presented (e.g., time since loss, relationship with the victim), not allowing more general and robust conclusion.
- Mixed samples (i.e., different causes of violent deaths) are not always clearly described across the literature.
- Important variables, such as experiences of support (past or at the time of the interventions), experiences of trauma/violence pre-loss were not considered in the included studies.

Personal learning

The systematic review has given me the opportunity to improve my literature searching skills. In fact, I engaged with some training, as well as had mentoring meetings with a librarian expert in Psychology and Education at the University of Bath. Both strategies have definitely increased my knowledge and academic rigour when conducting general and systematic reviews. For example, we published the current systematic review protocol via PROSPERO prior to searches, as well as included a quality assessment tool to score the included records.

Concerning the state of the literature itself, this review demonstrated that limited evidence-based research has been conducted to date. Furthermore, confirmed some findings from the narrative literature previously conducted, which showed that homicidally bereaved individuals report severe and ongoing psychological difficulties post-event. Finally, this has highlighted that psychological interventions are likely to decrease symptoms (PTSD, depression), but more longitudinal mixed methods research is needed to understand the long-term effects of those interventions offered.

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Chapter 3:

"*Everything changes*": Listening to homicidally bereaved individuals' practice and intervention needs

Alves-Costa, F., Hamilton-Giachritsis, C., & Halligan, S. (published). "Everything Changes": Listening to Homicidally Bereaved Individuals' Practice and Intervention Needs. *Journal of interpersonal violence*.

Chapter Rationale

Chapters 1 and 2 demonstrated that homicidally bereaved individuals were likely to report severe and ongoing psychological difficulties post-loss. However, limited attention has been paid to the voices of those experiencing the negative outcomes. Therefore, this qualitative study (Chapter 3) provides a realistic and inclusive account about the personal experiences/journeys in the post-homicide reality. Focus is based upon participants' perceptions about themselves, the impact of the event, and experiences of support.

This manuscript has been submitted to the Escaping Victimhood team for approval prior to submission to *Journal of Interpersonal Violence.*

Statement of Authorship

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<tr><td colspan="10">Everything changes": Listening to homicidally bereaved individuals' practice and intervention needs.</td></tr>
<tr><td colspan="10">Publication status (tick one)</td></tr>
<tr><td>Draft manuscript</td><td></td><td>Submitted</td><td></td><td>In review</td><td></td><td>Accepted</td><td></td><td>Published</td><td>X</td></tr>
<tr><td>Publications details (reference)</td><td colspan="9">Alves-Costa, F., Hamilton-Giachritsis, C., & Halligan, S. (2018). "Everything Changes": Listening to Homicidally Bereaved Individuals' Practice and Intervention Needs. Journal of interpersonal violence, 0886260518766558.</td></tr>
<tr><td rowspan="2">Candidate's contribution to the paper (detailed, and also given as a percentage)</td><td colspan="9"></td></tr>
<tr><td colspan="9">Filipa Alves-Costa made considerable contributions to the conception of the study (50%), as well as the methodological design (70%).The experimental work, including the acquisition, data analysis and interpretation of was predominantly conducted by Filipa (90%). Filipa has also executed the presentation of the data in journal format (90%), as well as presented its content at national and international academic conferences, and non-academic events (e.g., Escaping Victimhood Art & Photo Exhibition) in order to impact policy decisions (100%).</td></tr>
<tr><td>Statement from Candidate</td><td colspan="9">This paper reports on original research I conducted during the period of my Higher Degree by Research candidature.</td></tr>
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Running head: The needs of homicidally bereaved individuals.

"*Everything changes*": Listening to homicidally bereaved individuals' practice and intervention needs

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Acknowledgments and credits

The authors would like to thank all of the individuals that took part in this study for their engagement with the research. The authors would also like to 'Escaping Victimhood' and Andrea Pintos for all of their support.

Funding information

This work was supported by Escaping Victimhood and the University Bath Graduate Studentship Allowance (collaborative scholarship).

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Abstract

Objective: This study sought to understand how individuals bereaved through homicide, (murder or manslaughter) describe their post-event experiences to inform clinical needs and promote mechanisms for change.

Method: A total of 21 participants (18 females) between the ages of 29 and 66 [mean (M) age = 47.81 years, standard deviation (SD) = 8.99] took part in this study. They were all participating in a residential programme for homicidally bereaved individuals and were all resident in the United Kingdom. The sample comprised of twelve parents, five siblings, one partner, one daughter, one friend and one grandmother of the deceased. The length of time since the bereavement varied from 12 months to 18 years (*M* = 2.48; *SD* = 1.80). Thematic analysis was used to analyse the narratives collected.

Results: Three central themes emerged, namely: 1) *uniqueness of the experience*, 2) *changed self & world*, and 3) *mixed experiences of support*. The uniqueness of the individuals' experiences was associated with the nature of the homicide event and the consequences that are unlikely to occur in 'normal' deaths (e.g., judiciary). A sense of a changed self (e.g., ongoing emotional/mental and physical responses, coping) and world (e.g., changed beliefs regarding safety and criminal activity) seemed to be contributing to different shades of (mal)adjustment. Strategies for coping were identified.

Conclusions: The current study with a large qualitative sample generated a unique, rich description/integration about individuals' journeys following an experience of homicidal bereavement. Findings are likely to inform policy and clinical practice by considering individuals' voices.

Keywords: homicide, bereavement, murder/manslaughter, impact/outcomes, experiences of support.

"*Everything changes*": Listening to homicidally bereaved individuals' practice and intervention needs

Given that over a quarter of a million individuals were killed by homicide in 2015 (United Nations Office on Drugs and Crime [UNODC], 2017), it is important to understand the impact on those left behind. Data suggests that the homicide rate in the United States of America was 49 per million population in 2015 (The Department of Justice and Federal Bureau of Investigation, 2015). United Kingdom figures demonstrate that there were 709 homicides in the year ending March 2017 (Home Office Homicide Index, 2018).

For each of those killed by homicide, there are usually several individuals who had close relationship with them and are left behind. Following 'normal' bereavement, research has shown that 45%-50% of individuals tend to respond resiliently. More specific, they demonstrate what it is categorised as 'normal' grief pattern reactions and adjusting over time, albeit with some possible cultural/individual differences (Bonanno & Kaltman, 2001). However, when deaths occur under violent circumstances this may promote bereavement distress characterised by severe emotional responses that may persist for many years (e.g., Amick-McMullan, Kilpatrick, & Resnick, 1991; Connolly & Gordon, 2015; Holland & Neimeyer, 2010; Rock, 1998). Understanding this phenomenon has relevance for ongoing individual well-being and service provision.

Homicidal bereavement has several characteristics, such as the unexpected, (often) deliberately and violent nature of the event, which may distinguish it from other violent bereavement experiences (e.g., due to terminal illness, suicide, accidental death). Moreover, the available evidence suggests that homicidally bereaved individuals are at an increased risk of developing a variety of psychological difficulties, including: posttraumatic stress disorder (PTSD), depression, anxiety, substance abuse and complicated grief. Indeed, a systematic review demonstrated that the prevalence of

PTSD ranged from 19.1% to 71% across studies (van Denderen, Keijser, Kleen, & Boelen, 2014). Which is relatively high when compared with other forms of traumatic exposure, e.g., among war veterans. It is estimated that PTSD responses in this context range between six and 15% (National Centre for PTSD). Furthermore, research has shown that among individuals seeking treatment for prolonged grief (not only individuals bereaved through homicide), a high percentage demonstrated comorbid conditions between depression and PTSD, for instance.

Regarding grief responses post-loss, it is estimated that the majority of adults, children and adolescents will show the ability to grieve and adapt (Prigerson, 2004), showing healthy levels of psychological and physical functioning in the first 12 months post-loss (Bonanno, 2004). Nevertheless, around 10 percent of the bereaved population are likely to require professional support (Shear et al., 2011). Thus, Complicated Grief (CG)[18] consists of an overall ongoing grief response, in particular intense yearning, searching for the deceased, disbelief about the death, or an inability to accept the loss, as well as experiencing intrusive thoughts/images of the death (Prigerson et al., 1995). Additionally, individuals may be unable to work and to maintain social interactions (Shear, 2015). Thus, CG within ten years of bereavement was found in 2.4 percent among the general population (Fujisawa, Miyashita, Nakajima, Kato, & Kim, 2010), but rates of prolonged grief disorder (PGD) can actually be higher following the death of a partner or child under unnatural or violent circumstances (10%; Boelen & Smid, 2017). Other studies have also demonstrated that unexpected, sudden and violent losses were linked with greater CG responses. (e.g., Currier, Holland, & Neimeyer, 2006; Parkes, 1993; Shear, 2015). However, evidence-based research is somewhat limited among

[18] CG is also termed as *prolonged grief disorder* (Boelen, Van de Schoot, Van den Hout, De Keijser, & Van den Bout, 2010), *complicated grief disorder* (Maercker, & Znoj, 2010), *pathological grief* (Jacobs, 1993), *traumatic grief* (Jacobs, Mazure, & Prigerson, 2000), and *persistent complex bereavement disorder* (PCBD, American Psychiatric Association, 2013).

homicidally bereaved individuals, therefore it is difficult to estimate the CG prevalence accurately as noted by Rynearson, Schut and Stroebe (2013).

Looking more broadly, suicidal ideation, hostility, insomnia, early mortality and a high predisposition to risky behaviours (e.g., drug and alcohol consumption) have each been linked to homicidal bereavement experiences (Currier et al., 2006; Rheingold & Williams, 2015; Rheingold, Zinzow, Hawkins, Saunders, & Kilpatrick, 2012; Zinzow, Rheingold, Byczkiewicz, Saunders, & Kilpatrick, 2011). Financial difficulties as well as social/community level problems often occur, as a result of the homicidal bereavement experience (Clements, DeRanieri, Vigil, & Benasutti, 2004; Malone, 2007). In contrast, the majority of bereaved individuals (especially following 'natural' deaths) are likely to adjust after a short period of potential distress, and impaired functioning (Bonnanno & Kaltman, 2001).

Despite these observations, such as the relatively broad range of adverse outcomes, the experience of homicidal bereavement and its features, it still remains relatively understudied when compared with other potential interpersonal traumatic/abusive experiences (e.g., domestic and sexual abuse). In addition, there are few adapted and tested interventions for this client group [*names removed for masked review, in submission*]. Few interventions have been developed for adults (e.g., Rheingold et al., 2015; Saindon et al., 2014, or for children and adolescents (e.g., Salloum, 2008; Salloum, Avery, & McClain, 2001) that have been through an experience of homicidal bereavement, mainly in the United States of America. Some exceptions to this are charities such as *Winston's Wish UK*[19] (children), Victim Support (*Homicide Service*; adults)[20], *Support after murder and manslaughter*[21] (adults) and,

[19] *Winston's Wish UK*: https://www.winstonswish.org.uk.

[20] *Homicide Service:* https://www.victimsupport.org.uk.

[21] https://www.samm.org.uk/.

The Moira Fund[22]. In the UK, these charities offer immediate and helpful support, but models of intervention are unknown and, hence, it is difficult to be clear about adaptations and research-based suggestions/generalisations. Also, some support are available only during the court processes. Therefore, despite the positive effect of these interventions, this study aimed to increase understanding about the phenomenon by listening to individuals' voices.

Alongside the limited evidence relating to the negative experiences associated with homicidal bereavement, there is also sparse information about how individuals perceive their post-event experience; especially on how processes and changes are perceived to have occurred over time. Furthermore, the small amount of research to date is quantitative in nature, with little attention to details paid to the voices of those experiencing these negative outcomes. Therefore, the purpose of this study is to provide in-depth analysis of how homicidally bereaved individuals describe their personal experiences/journeys in the post-homicide reality. Focus is based upon their perceptions about themselves, the consequences of a homicidal bereavement experiences, their (unique) needs of support and the ways in which they cope when a loved one was killed. Specifically, this research was guided by the following analytic questions:

a) How do individuals describe their experience post-homicide?
b) How do individuals perceive both formal and informal support?
c) What coping strategies do individuals engage with?

Context: Escaping Victimhood

Participants were recruited from a homicidally bereaved holistic programme offered by a UK charity, Escaping Victimhood (EV)[23]. Heath/social workers (e.g., Victims support, Homicide support) usually refer individuals to attend an EV workshop; however, they can self-refer themselves by contacting the charity directly.

[22] http://www.themoirafund.org.uk/.

[23] More information about the EV programme can be found on their website: http://www.escapingvictimhood.com/.

The goal of EV is to support individuals whose lives have been disrupted by the trauma of a serious crime experience, particularly from homicidal bereavement. EV offers a four-day residential holistic group programme (up to 12 individuals on each programme to allow for individualised response) to individuals affected by homicide. Briefly, EV offers a psychoeducational and experiential intervention aimed to empower individuals bereaved through homicide or manslaughter. They deliver informative workshops about traumatic reactions, emotional and physiological responses (e.g., why and how certain symptoms, responses and reactions occur), as well as coping strategies aiming to promote a 'better' adjustment after losing a loved one in such circumstances. In addition, their holistic philosophy incorporates experiential activities such as photography, art and therapeutic messages aiming to promote wellbeing, and reinforce the possibility of engaging with such activities in the future. Individuals who attend EV workshops are, by default, those who are struggling to cope following homicidal bereavement experiences.

Method

This study (and the wider longitudinal study) received ethical approval from Psychology Ethics Committee at the University of Bath (Ref. 14-186) and the British Psychological Society. In addition Health and Care Profession Council ethical guidelines were followed. Internal processes were completed for approval at EV. In brief, the welfare of participants was paramount, including anonymity of data, informed consent and right to withdraw, with a plan carefully developed in case participants showed signs of distress or anxiety during the interview.

Paradigmatic underpinnings

This study presents the qualitative element of a wider research project (i.e., mixed methods approach), and, although the current paper reflects a micro study of the longitudinal study, it is important to reflect on the paradigm and philosophical

perspective. Pragmatism is generally regarded as the philosophical paradigm for the mixed methods approaches, as it attempts to provide a distinction between what are considered a) purely quantitative approaches based on a philosophy of (post)positivism and b) purely qualitative approaches are based on a philosophy of interpretivism or constructivism (e.g., Maxcy, 2003).Thus, this qualitative study complements the quantitative data (reported elsewhere) to better understand the underlying processes of these individuals (as per Smith, Tomasone, Latimer-Cheung, & Ginis, 2017).

Recruitment/participants

Qualitative interviews were conducted with homicidally bereaved individuals who were attending a residential EV programme. Interviews were conducted 1:1 by the researcher who was not part of the EV team, on the second or third day of the programme. EV participants had experienced the loss at least one year prior to the interview; were aged 18 years or older when the interview was conducted.

Four groups were held between September 2014 and June 2015 (N = 30), participants were approached for this qualitative study. Individuals were pre-informed about the study by the EV team and, if willing, agreed to take part on the first day of the EV programme. In total, 21 (70%) individuals agreed: the resultant sample comprised of three males and 18 females with a mean age of *M* = 47.81 years old (*SD* = 8.99; range 29-66) residing in the United Kingdom. Highest educational qualifications achieved were as follows: GCSE/O-Level/Equivalent, n = 10 (i.e., education until 16 years); A-Levels/Equivalent, n = 4 (18-years); post-graduate certificates, n = 5; and Professional Degree, n = 2). The sample comprised 12 parents, five siblings, one partner, one daughter, one friend and one grandmother. The length of time since the bereavement at the time of interview varied from 12 months to 18 years (mean = 2.48; SD = 1.80; range = 5).

Semi-structured interview and data analyses

Semi-structured interviews conducted with the individuals. More specific, participants were asked to discuss their interpretations, perceptions, opinion about their post event experiences, their participation on the EV programme and their experience with both support and legal services. Interview questions were developed based on a cross-literature search in a variety of areas, including: interventions, emotional responses, psychopathology, homicidal bereavement experiences and victimology. These were validated by the EV team (experts working in this field for several years) was involved by providing feedback and suggestions in the generation of interview questions. In addition a pilot group, a pilot group was run in September 2014 and changes to the interview protocol were made following participants' feedback and from the researcher's self-reflection on the interview. Thus, two main changes were made: 1. five questions were merged, as they shared very similar content (e.g., coping strategies and patterns post-loss), and 2. Technical and academic language was substituted by *more* simplistic terminology (e.g., psychological difficulties or emotional issues instead of psychopathology).

All the interviews were audio-recorded and transcribed verbatim ready for coding. Duration varied from 20 minutes to two hours.

Interviews were analysed using an inductive *Thematic Analysis* method (Braun & Clarke, 2006). All the analyses were supported through the use of *QSR NVivo10* software.

The process of data analysis occurred in different phases/steps, as suggested by Braun and Clarke (2006). The first author was immersed in the data and became as familiar with it as possible. This process occurred by transcribing the audio recordings and by reading the transcripts several times before actually starting the analysis. In the primary stage, the first author went through the coding process independently. The

coding system was gradually generated, as she was focusing on domains related to this subject (e.g., elements as feelings, perceptions, changes, opinions and suggestions were robustly searched). In a second phase, and in order to insure academic rigour and reliability, an independent coder (a final year graduate student in Psychology) preformed blind coding for 10 percent of the interviews. In a third stage, the first author and the external coder established comparisons between the two coding systems generated. This process revealed that there was a high level of agreement between the themes and subthemes generated. Results from *Cohen's K* test indicated a substantial level of agreement (k = .759, p = .003). Furthermore, the second author checked both coding systems and it was decided that the themes 'changed self' and 'changed world' (initially two separate themes) should be merged, due to the overlap between the two. Finally, a third independent coder was involved (third author) in order to check the themes and subthemes and, together with the first and second authors the coding generated was validated.

Results

Three overarching themes emerged from the thematic analysis: 1) *Uniqueness of the experience*, 2) *Changed self & world* and, 3) *Mixed experiences of support*. Each of these was comprised of several subthemes, as detailed below. Mind-mapping figures are presented to summarise the findings.

Theme 1: Uniqueness of the experience

The first theme reflected participants' narratives about their perception of being bereaved through homicide, including how they describe their post-homicide reality. In particular, individuals reflected on the potentially "*unique"* experience that they have been through. Thus, several very concrete examples (subthemes) were given by the participants which illustrate how they 'see' and 'feel' the post-loss. Sub-themes consistent with this perception of having been through a unique experience were as

follows: 1) the sudden, unexpected and violent nature of the event, 2) the protracted legal/criminal processes and sometimes inconsistent aims of individuals versus the State; and 3) the dual private but also public nature of their grief processes (Figure 1).

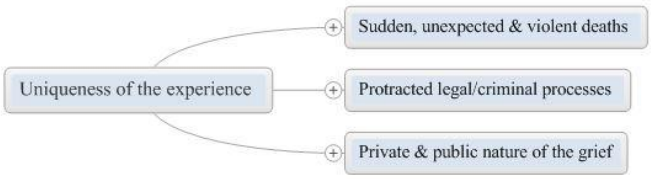

Figure 1. Uniqueness of a homicidal bereavement experience.

Firstly, the vast majority of the individuals reflected on the nature of the death. This was perceived as being particularly unique when compared to other causes of loss (e.g., following non-violent circumstances). Thus the first sub-theme - ***sudden, unexpected and violent nature of the event*** **–** was mentioned by 19 participants. The sudden and unexpected nature that characterises a death by homicide may occur under other circumstances (e.g., accident, suicide), yet it was possible to understand how difficult it was for these participants to deal with that. For example, participant 010 said that her son went *"out and* [she] *never saw him again, it was like that!* [She] *had not had time to say bye or how much* [she loved] *him. You just do not think those tragedies happen to you*".

Furthermore, and as noted by almost all of the participants (n=20), the often deliberate nature of a homicide is a key factor that differentiates their experiences to others, as mentioned by participant 06: "*we have had many other deaths in the family but, you cannot compare, they were natural, this is just another level, someone intended to kill her*." Participants also reflected about the potentially extremely violent nature of a homicide and how their loved one must have experienced a lot of pain in their final moments of life. Thus, as an example another participant stated that:

> *It is horrible thinking about what the* [perpetrator] *did with my sister*. O*nly parts of her body were found, we did her funeral with a small box*. *And I cannot really think about her pain*. *I cannot think about her suffering, it is terrifying* [Participant 08].

Also, as participant 07 said: "*I just cannot get my head around the* [victims'] *last hours, her body was, and her body was, the blood, her face, her face. She was in agony."*

The second subtheme relates to the ***protracted legal/criminal processes and sometimes inconsistent aims of individuals versus the State*.** Almost all of the individuals (n=19) identified the criminal and legal processes that follow the homicide as an element that is very unlikely to occur among other deaths. For example, participant 018 noted that: "*the legal system involved, is not normal, you do not go to the court if it is natural, if it happens by illness or aging. I did not go through this when my parents died.*"

Furthermore, the criminal and legal processes immediately after the event, are for the majority of them (n=18) something that they are not 'skilled' enough to understand. In fact, the "*lack of information"* regarding those systems, in particular not knowing how it works and progresses, is seen as an additional source of stress that is likely to increase their maladjustment. As noted by participant 06: "y*ou have to fight and fight and fight to get some information about what is going to happen, you do not get this if you lose a loved one in normal circumstances, do you?*."

Linked with the nature of the criminal and legal proceedings, participants described an inability to fully grieve and process the loss. In fact, 19 participants shared the sentiment expressed by Participant 19 that "*just* [wanted] *to grieve, but* [you] *cannot, as* [you] *are too busy trying to understand the legal system. Trying to find the*

person who killed your loved one. You are busy, you are busy."[Participant 19]. Building on that, the majority of participants (n=17) reflected on the apparent dissimilar aims between homicidally bereaved individuals and the State. On the one hand, the State's aim is to follow the legal and criminal pre-established rules to reach 'justice', with guilt or innocence established at the end of the process, as shared by participant 04: "*their job is over when the legal process finishes, when they caught the person who killed your loved one*." On the other hand, for homicidally bereaved individuals, the end of the legal and criminal processes were described as the beginning of their grief process, as noted by participant 08 they "*start grieving when the legal side is finished."* Consequently, almost every participant (n=20) identified these dissimilar aims as contributing to the lack of further support (both formal and informal) after sentencing. In addition, individuals (n=18) believe that having had the opportunity to understand better, as well as to know what to expect from those criminal and legal systems would have been beneficial, as it was said by participant 015, "*when you know, you feel that you can control things a bit better, rather than having surprises.*"

The third subtheme relates to the ***dual private and public nature of the grief process following a homicide***. Individuals' narratives (n=12) described the media coverage on the aftermath as contributing to the public (instead of private) nature of their grief and not likely to occur following other deaths. Moreover, participants (n=9) have described the media's interactions as disrespectful towards their families and loved one's memories, as well as lacking of tact and empathy. Participant 04 stated that "*the press wants to know everything about* [their] *loved one, about* [their] *family* and *sooner or later they start judging you*." Moreover, participant 021 added that "*the media are at your front door and you just want to hide yourself from the society. And do they really care about you? No, they do not! They want to get a sensationalist story that sells, that*

is what they want." This led to a perceived social/self-stigmatisation following the homicide, as several individuals (n=8) shared that they felt exposed, even when they were not *the victim, but it made them more vulnerable and known*", as noted by participant 021.

Finally and directly linked with the participants' difficulties, financial changes were also reported by 12 participants, as a direct consequence of the homicide event with this leading to additional distress.

Theme 2: Changed self & world

The second major theme related to how individuals define themselves and their reality following the homicide. Subthemes emerged, as follows: 1) changed mental/emotional health, 2) changed perception of the world, and 3) changed manner of coping (Figure 2).

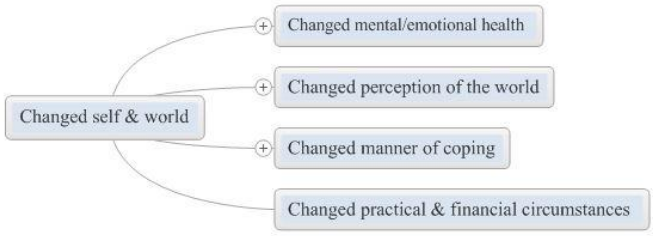

Figure 2. Changed self & world post homicide.

Participants' narratives (n=21) described a ***changed-self*** post homicide where severe psychological difficulties were felt since the event. In fact, they described significant changes in their overall wellbeing. The most commonly symptoms reported were compatible with traumatic responses, as noted by participant 019: "*the shock, the trauma, the trauma, you just see everything happening again and again in your head, no matter if you are asleep or not."* Furthermore, grief responses were also seen as disturbing, due to the "*intrusive images*" of the victim's body, as well as overall apathy

and depressive symptoms (participant 3). The lack of energy was linked with their lack of motivation, for example participant 013 noted that she: "*just lost interest and motivation to do things, to see people, to talk with them about random things. At work is difficult as well, especially in the morning, because* [her] *head is not really there.*"

In addition, individuals (n=19) described an overall lack of energy and feeling of exhaustion that prevented them from "*function[ing] at all"* [Participant 4]. Moreover, physical issues were reported by several participants (n=9), namely eating and sleeping disturbances.

Beyond the psychological difficulties, more than half of the participants (n=12) have also described changes in their emotional system, where they often feel guilty for having a life without their loved ones (n=9), as well as irritable, frustrated and overly angry, as the following narratives exemplify:

> *I feel guilty, you know? Guilty with very minor things going to the park with my grandchildren, for example*. [Participant 12].
>
> *I get angry* very, very easily now *all the time. Small things make me feel that way, even watching movies that reminds me of* [my sister].[Participant 10].

It is important to note that the vast majority of individuals (n=19) linked the outlined impacts with a belief of having an abnormal response given the severity and persistence of the symptoms. For example, participant 021 said that:

> *You think you are going crazy, you just do not know what it is happening, your body has this very strange reactions, your mind is never in silence and then you just think that you are mad and that all is a matter of your imagination*.

However, knowing that their experience is not a unique case and that other people develop similar (mental/emotional and physical) responses, was perceived as being beneficial by 18 participants as they have seen their own responses normalised, participant 07 noted that they "*are part of an exclusive club, where* [they] *share the same pain.*

The second subtheme – ***changed world*** - relates with their changed worldviews post-homicide. In fact, 10 participants reflected on their changed self and world, and how it contributed to their (mal)adjustment. This is particularly demonstrated due to their inability to integrate the homicide in their overall experience. In fact, a number of participants (n=15) described a new system of beliefs regarding overall safety and trust issues, as well as an increased awareness regarding criminal activity and how ordinary people (such as themselves) can be affected by it. Some examples included:

> *I think before I didn't think about crimes and things like that, because you do not have to, you see things on the news and you read things in the newspapers, but it is always very distant from you*. [Participant 020]
>
> *I trust my friends which I always have and they have been there for years and I'm very lucky in that way. With others I'm very careful*. [Participant 5];

Regarding the individuals' changes (self and world), several participants (n=10) demonstrated an overall confusion due to an identity that was no longer recognised as being part of their own and contributed to an unrealistic will of '*going back to* [their] *normal'*. Furthermore this was linked with the failure to find meaning to validate those changed identities, as it was noted by participant 02:

> *I need to get myself back, I need to be able to somehow to get back my true self and go back to who I was before this happened, because now I don't live, I function*; *I don't live, I function.*

In contrast, a sense of reorganisation/adjustment was described by a third of participants (n=7), demonstrating a *more* positive attitude towards their changes. Although those participants acknowledged a changed self and reality post-homicide, they also noted that all the changes might reflect a new identity, as said by participant 09, for instance: "*I know that I'm not the same person that I was before, and I will never be. This is my new normal."*

Finally, the third subtheme related to the individuals' *changed manner to cope*. In fact, 10 participants said that they found it harder to cope with day to day issues post-homicide. On the other hand, despite the difficulties coping, some participants also listed a number of active strategies that they had been undertaking to help them with the homicidal bereavement experience, including: spending time with family (n=10), having short/medium term aims and goals (n=5), accepting help (formal and/or informal; n=5), sports and exercising (n=4), and accessing information about the legal process and post-homicide responses (emotional and physical) (n= 19). Self-protective or avoidant coping strategies were also described, including: taking things '*day by day*' as the future seems unpredictable and uncontrollable (n=15), keeping busy and avoiding thinking about the homicide event (n=10), avoiding places and/or activities in order to avoid possible reminders (n=11), alcohol consumption (n=5), and hiding feeling and emotions in order to protect relatives (n=10).

Theme 3: Mixed experiences of support

This theme summarises the participants' experiences regarding the sources of support post-homicide. Participants reported both informal support shown by family, friends and colleagues (n=15), and formal support offered by different services (n=21).

Regarding ***support received***, 18 participants described an overall positive/satisfactory experience of support (both formal and informal). Primarily, individuals found it helpful receiving some information immediately after the homicide (e.g., police officers). Furthermore, almost all of the individuals (n=15) mentioned that having been helped with day-to-day practicalities/issues (e.g., paying bills, planning meals), and this was seen as very "*important, because you just don't care about anything really"*, as noted one participant (07). However, it was clearly identified as not '*enough'* by 15 participants. In fact, almost all sources of support ceased when the legal process finished (or not long after). This period of time was described as a critical turning-point where individuals start (truly) grieving for their loved one's death, and where continued support was consequently particularly needed, as was mentioned earlier. Thus, 16 participants reflected on their current need for continued formal support (sometimes many years after the event), due to their ongoing and severe psychological difficulties. In fact, the EV workshops were mentioned for the majority of those participants (n=12) as extremely useful, as it provided the 'right tools' to help them understand post-homicide responses and which strategies and/or interventions/treatments might help them to reach a better adjustment over time.

Finally, about half of the participants (n=10) reflected on an unfair 'system' that mainly focuses on the perpetrators' needs, due to the established sources of support, care and treatment/interventions within prisons for offenders. In comparison, they described the uncertainty and perceived lack of care post-homicide experienced by family and friends of the deceased. As noted by participant 05, the perpetrators "*get all*

they need in the prison, they get mental services for free, and they are there for them. People look after them, this is just not fair."

Regarding informal support, 15 participants mentioned having felt supported by relatives and/or friends post-event. However this was not always perceived as effective, as "people d*on't know what to say, they don't say anything then, which is even worse*" (participant 011), or "*avoid the topic"* when individuals "*would rather be asked about* [their] *needs and what they can offer to help*" (participant 3).

Finally and regarding the overall perception of being supported, 15 individuals said they felt they had not been fully understood by people (in the context of both formal and informal support) who have not been bereaved through similar circumstances. This comprised a perceived inability of others to empathise, feel and think similarly. Therefore, participants believed that without having been through the 'same experience', individuals cannot fully and holistically understand their experiences. Furthermore, the perception of not being understood was linked with a tendency for isolation post-homicide, as it seemed to be an easier and safer path to take.

In terms of recommendations for practice, some participants described the need for a clear structure in relation to where they can seek professional support, how legal processes are likely to progress over time (n=8), longer periods of support (n=15), humanized professional support (n=7) and specialist professionals (n=9). On the other hand, for social awareness purposes, several participants (n=10) noted that more education is needed regarding how to respond to grief, because they are likely to be wrongly labelled *as "mental or mad"*, but their "*bodies and minds are only reacting to a horrific experience*", as for example said by participant 8.

The qualitative nature of this study demonstrated that the majority of the individuals (n=18) found the journey itself (to get to the EV programme) challenging. For example, several participants (n=9) reflected upon to the fact that they the first time

that have commuted it since the event. On the other hand, the fact that they have done, it was described as an important achievement and gave them a sense of self-efficacy.

Discussion

This is one of the few large scale qualitative approach studies aiming at understanding post-homicide experiences. Previous research has focused mainly on clinical impact post-homicide and general coping mechanism.

The qualitative study conducted with 21 homicidally bereaved individuals (during their attendance at the EV programme) captured participant descriptions of their perceptions of the post-homicide reality. Indeed, this study describes how they 'see' and 'feel' their experience as *unique* when compared to other general adverse experiences and to non-violent losses, in particular, and is likely to inform practice and policy.

The nature of the homicide itself (i.e., often sudden, unexpected, deliberated and violent) seems to have increased individuals' suffering in the aftermath. This was in line with other studies, where the violent and intentional elements that characterise a homicide were linked with ruminative questions and thoughts about the event per se (e.g., death, body, crime scene) with this leading to overall poorer adjustment and increased CG symptoms when compared to other causes of death (e.g., Currier et al, 2006; Shear, 2015; Parkes, 1993).

Moreover, the criminal investigations (and often missing body) and legal processes were described in this study as additional elements of distress. This is consistent with several studies that have described individuals' perceptions about the legal-criminal processes, with the vast majority highlighting poor experiences, especially due to the lack of information about how it works and progresses over time (e.g., Armour, 2003; Malone, 2007a, 2007b). In fact, a more victim-oriented justice process might prevent the exacerbation of psychological difficulties post-homicide and secondary victimisation (Englebrecht, 2011). In addition, the media intrusion was described as negatively impacting on individuals. Our findings are consistent with existing limited research findings relating to negative media impacts, which have led to

suggestions that training on 'emotional literacy' should be provided to allow journalists to engage with and empower homicidally bereaved individuals (Malone, 2007).

Taking into to consideration the very particular elements post-loss outlined, perhaps unsurprisingly, individuals described themselves as changed by the homicide, where intense psychological responses were reported. (It is also worth noting that this sample consisted of a group who had continued to have difficulties even after other forms of support.) Previous research has reported high levels of psychopathology post-homicide, namely PTSD, CG and depression (e.g., Rheingold & Williams, 2015; van Denderen, de Keijser, Huisman, & Boelen, 2016). Furthermore, participants in this study shared changed professional and financial roles and worldviews, as was also noted by Malone (2009). Moreover, the changed world was, in this study linked with the individual's inability to adjust and wishing to "*go back to their normal*". Other studies have linked this with feelings of alienation and social isolation (Miller, 2009).

Finally, their perceptions of mixed experiences of support (not always positive) led to suggestions to improve formal support, where a clearer plan of action could be implemented, showing the paths that individuals need to follow to get support and information. According to participants' narratives, support experiences could be improved in the future by providing: a) advice about the legal process, and about what services/treatments are available, b) clear information about what mental/emotional and physical responses are likely to occur post homicide, and c) ongoing support (after the legal processes). In fact, knowing responses that are likely to occur post homicide and having a greater understanding about how legal procedures work, as well as being mindful about not being 'a unique case', were described as helpful and adaptive coping strategies.

Other research has shown that individuals were generally dissatisfied with their experiences of different services (in particular, their interactions with the criminal

justice system), but that strategic planning together with community agencies and police departments could support individuals in gaining access to the right services at the right time (Rheingold & Williams, 2015).

Some authors have suggested that additional support may need to occur in people's home and/or local communities (Aldrich & Kallivayalil, 2013), but our study did not support that. Instead the contrary seemed to be the case. Although participants found it very difficult to get to the EV residential programme (a 'journey' in itself – both physically and mentally), the benefits of doing so were immense (reported at the time of the intervention). However, it is worth noting that the fact that the locations were often such a large distance away did mean that some did not manage the journey. Hence, additional provision of residential programmes around the country would shorten journeys and could facilitate greater attendance at such programmes for those individuals who have are still experiencing ongoing, long-term difficulties despite interventions from other sources, such as Victim Support.

Regarding informal support, it appears to be important to increase social awareness about grief in general and homicidal bereavement in particular, where individuals adopt a direct, but tactful attitude towards those affected. Actually, participants described their preferences to be asked about how they could be supported, rather than being avoided. This might relate with wider societal difficulties in responding to death and dying (no matter its cause), where this has become something of a 'taboo' subject with individuals lacking skills to engage with such experiences (Chapple, Ziebland, & Hawton, 2015).

Finally, and in terms of individuals' adaptation, two different shades of (mal)adjustment were identified: an unrealistic desire for '*going back to* [their] *normal'* and by the contrary integrating their identity as their "*new normal*". However, the interviews took place while individuals were attending the EV intervention, and it

would be important to understand how they have progressed afterwards (a mixed methods longitudinal study has been conducted and future manuscripts will look at this closer). Nevertheless, and taking in consideration the participants' narratives, some show a *more* positive approach and described themselves as ready to begin their journeys to the adjustment (*new normal*-approach). On the other hand, those who have a desire to *go back to their normal* may require further assistance in developing better integration of their 'new' self with their old identity.

This study supported previous somewhat limited research and highlighted new pathways to understand the experiences of those bereaved by homicide. Avenues of clinical support were discussed and future practice could consider the individuals' voice in order to help them/promote their adjustment to a possible "new normal" in a changed reality. Considering the findings from this qualitative study, individuals report themselves changed by the post-homicide and their narratives highlight distress and maladjustment. It appears that old and new identities (pre and post-homicide, respectively) appear to compete with each other and impair their ability to adjust. Thus, future research and clinical strategies of support could explore the meaning those changed identities/selves why and how they been changed by their experiences, for instance, in order to increase insight about a new/changed reality. In fact, it would be perhaps surprising if such potential traumatic experience did not change them. Thus, new clinical avenues could help them to holistically find the meaning for their experiences and build a strategic plan where a "new normal" can emerge and increase their overall wellbeing.

Limitations and future research

Despite the positive contributions of this study, there were some limitations. In particular, some of the questions might have been too broadly phrased (e.g., "What sort of support did you get"), as per that suggested by qualitative analysis. However, greater

use of additional prompting might have been useful in developing even richer narratives. This could have contributed to a better understanding about what support individuals received previously, where from (e.g., GP, police, charities) and its structure/settings (e.g., psychotherapy, counselling).

Secondly, this study would have benefited from the inclusion of individuals that had not attended the EV programme in order to maximise knowledge on different experiences of support and personal journeys. However, attempts to find community samples were unsuccessful, hence should be an area for future research. Furthermore, mainly females participated in this study, therefore it was not possible to explore possible differences between males and females, and future studies should address this limitation better. This has also been seen among the majority of the EV group interventions where only a few males took part up to date. In fact, this might raise some possible questions that should be considered in future research (e.g., do males engage with groups of support?).

In addition, it is important to note that the EV participants are often individuals that seem to struggling the most, demonstrating particular difficulty coping (even when they have been supported by other national services). Thus, this highlights the need to conduct studies with community groups of participants both seeking and not seeking support and explore if those groups differ (or not). Indeed, EV participants are often individuals that seem to be struggling the most, demonstrating particular difficulty coping (even when they have been supported by other national services). In fact, pre-intervention assessments demonstrated that individuals reported symptoms considered clinically significant for PTSD, grief responses and overall mental health. Those findings show that individuals have the need to be followed for longer periods of time (post-court), as well as that they might require structured clinical interventions to decrease the severity of those symptoms.

Importantly, personal characteristics (e.g., experience of other adverse experiences) and social interactions (e.g., perceived support) prior to the homicidal experience are likely to impact on how individuals cope and manage adverse experiences. Thus, future research should consider how personally types, past experience of trauma and support, for instance influence the individual's response to their experience of been through an experience of homicidal bereavement.

Finally, it is important to note that greater use of additional prompting might have been useful in developing even richer narratives, but this was not used and it might need to be seen as a potential limitation.

Conclusion

In summary, considering the findings of this study, individuals described patterns of severe psychological and social difficulties, and would benefit from receiving: a) advice about the legal process and about what services/treatments are available in early stages; and b) ongoing support/longer-term support (after the legal processes). In fact, knowing responses that are likely to occur post homicide and having a greater understanding about how legal procedures work, as well as being mindful about not being 'a unique case', were described as helpful and adaptive coping strategies.

Regarding informal support, it appears to be important to increase social awareness about grief in general and homicidal bereavement in particular, where individuals adopt a direct, but tactful attitude towards those affected.

Personal learning

Part of the quantitative nature of this research (i.e., pre and post-intervention) occurred during the residential EV intervention. This was important, as it revealed how participants reacted to our request to fill in questionnaires. The majority felt comfortable and happy, but for some the language used was difficult to understand and there was the need for further explanations. Moreover, some participants have informally shared that

they would prefer to do the interviews rather than filling in the questionnaires. This might inform future research and would be interesting to understand if clinical interviews or other data collection strategies (e.g., biochemical markers) would generate the same as self-report measures.

In terms of research, findings of this study were in line with the first qualitative study developed (chapter 3) and previous research also, as it showed that individuals reported several changes post-homicide (e.g., severe and ongoing psychological difficulties, low coping mechanisms, and the need for further support).

On a personal level, this study required rigour, precision and organisations skills, as I was collecting quantitative data at different time points (both in person and by post), and I had to insure that all the process was been well managed. Furthermore, together with my lead supervisor, I developed supervision skills, given that three students were involved in our project to help with data in-put. Finally, and due to the longitudinal nature of this research, I had to develop knowledge of core statistical elements, such as missing-ness patterns and treatment and multilevel modelling for repeated measures.

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Chapter 4:

Longitudinal outcomes following homicidal bereavement and psychoeducational intervention

Alves-Costa, F., Hamilton-Giachritsis C., Pintos, A., & Halligan, S. (*in submission*). Longitudinal outcomes following homicidal bereavement and psychoeducational intervention *Journal of Clinical Psychology* [September 2017].

Chapter Rationale

Both literature reviews, as well as the qualitative study (chapter 3) demonstrated the high levels of distress among homicidally bereaved individuals. However, as noted, limited evidenced-based research was available regarding the progression of symptoms over time, as well as post-intervention. Therefore, a longitudinal (i.e., four time points) study was designed focusing on overall psychological difficulties, Post-traumatic Stress Disorder, Complicated Grief, as well as coping and resilience patterns.

This manuscript has been submitted to the Escaping Victimhood team for approval prior to submission to *Journal of Clinical Psychology*.

Statement of Authorship

<table>
<tr><th colspan="10">This declaration concerns the article entitled</th></tr>
<tr><td colspan="10">Longitudinal outcomes following homicidal bereavement and psychoeducational intervention</td></tr>
<tr><td colspan="10">Publication status (tick one)</td></tr>
<tr><td>Draft manuscript</td><td></td><td>Submitted</td><td>X</td><td>In review</td><td></td><td>Accepted</td><td></td><td>Published</td><td></td></tr>
<tr><td>Publications details (reference)</td><td colspan="9">Alves-Costa, F., Hamilton-Giachritsis C., Pintos, A., & Halligan, S. (in submission). Longitudinal outcomes following homicidal bereavement and psychoeducational intervention Journal of Clinical Psychology.</td></tr>
<tr><td rowspan="2">Candidate's contribution to the paper (detailed, and also given as a percentage)</td><td colspan="9"></td></tr>
<tr><td colspan="9">Filipa Alves-Costa made considerable contributions to the conception of the study (50%), as well as the methodological design (70%). The experimental work, including the acquisition, data analysis interpretation was predominantly conducted by Filipa (90%). Filipa has also executed the presentation of the data in journal format (90%), as well as presented its content at national and international academic conferences, and non-academic events.</td></tr>
<tr><td>Statement from Candidate</td><td colspan="9">This paper reports on original research I conducted during the period of my Higher Degree by Research candidature.</td></tr>
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Longitudinal outcomes following homicidal bereavement and psychoeducational intervention

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Acknowledgments and credits

The authors would like to thank all of the individuals that took part in this study for their engagement with the research and to 'Escaping Victimhood', especially Barbara Tudor, Clifford Grimason and Debra Clothier for all of their support for all of their support. Furthermore, the author would like to thank, Dr Célia Ferreira, Dr Leonel Gonçalves, Dr Michelle St Clair, Dr Miguel Araújo and Dr Teresa Braga for the shared statistical and methodological knowledge. Finally, the authors thank Bethany Webb and Theo Metcalf for their contribution to managing and inputting data.

Funding information

This work was supported by Escaping Victimhood and the University of Bath Graduate Studentship Allowance (collaborative scholarship).

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Abstract

Objective: This study aimed to understand longitudinal symptoms, coping and resilience following homicidal bereavement and attendance at a four-day residential psychoeducational intervention.

Method: Sixty-seven participants (predominantly female) took part in the study at pre-intervention assessment, 61 at post-intervention (91% retention), 37 at follow-up I (55%) and 33 at follow-up II (49%). Murder was more frequent than manslaughter and length of time since death ranged from 12 months to 10 years.

Results: Missing-ness pattern and systematic selective attrition analyses were performed. Posteriorly, multilevel modelling was conducted to estimate clinical fluctuation, coping and resilience trends. Despite unsurprising clinical psychopathology, there were statistically significant decreases over time (i.e., psychological symptoms, trauma and grief responses). Resilience mean scores were moderate (>50) at all-time points. Coping mean scores were low (<50); however, cognitive and emotional domains increased significantly between follow-ups.

Conclusions: This study has shown that some individuals who have been homicidally bereaved maintain severe levels of maladjustment and distress even following prior professional support. Importantly, though, a four-day residential programme demonstrated significant reductions in psychological difficulties measured on the BSI, trends towards significant reductions in levels of PTSD and grief responses, and increased coping. Thus, findings are likely to inform policy and clinical practice by reflecting individuals' needs across time.

Key words: Homicidal bereavement, psychological distress, interventions, coping, Escaping Victimhood.

Longitudinal outcomes following homicidal bereavement and psychoeducational intervention

The unique characteristics linked to an experience of homicidal bereavement (e.g., sudden, unexpected and violent nature of the deaths, protracted legal processes, as well as the dual private and public nature of the grief processes; *names removed for masked review, in submission*) seems to leave individuals with an increased risk of developing severe and prolonged psychopathology, such as depression, PTSD, anxiety and grief symptoms. Family, social and professional circles appear to be equally impacted (e.g., Amick-McMullan, Kilpatrick, & Resnick, 1989; Baddeley, et al., 2015; Currier, Holland, & Neimeyer, 2007; Rheingold & Williams 2015; Rheingold, Zinzow, Hawkins, Saunders, & Kilpatrick, 2012; Shear, 2012; van Denderen, de Keijser, Kleen, & Boelen, 2014). A systemic review (names removed for masked review, in submission) has identified a limited evidence-base measuring the efficacy of psychological intervention for homicidally bereaved individuals. Hence, identifying and understanding additional needs post-bereavement can assist in targeting interventions. Nevertheless, it appears to be a growing research area (e.g., Rheingold, 2015; Tuck, 2012).

The unique elements that characterise a death by homicide seem to increase the likelihood of more severe difficulties post-bereavement, namely the sudden, unexpected and violent nature of the event, the protracted legal processes, as well as the dual private and public nature of the grief, such as media coverage and court cases (names removed for masked review, in submission; Armour, 2002; Boelen, 2015).

Bereavement constitutes one of the most prevalent and distressful/challenging experiences across the lifespan (Shear, 2012). In a study conducted in six continents with 68,894 respondents across 24 countries (Benjet et al., 2016), it was estimated that 70% of adults reported exposure to a traumatic event and 31% of adults identified the

unexpected loss of a loved one as one of those traumas (the cause of deaths were not reported). Studies with children and adolescents have also demonstrated similar results (e.g., Breslau, Wilcox, Storr, Lucia, & Anthony, 2004; Kaplow & Layne, 2014; Layne, Kaplow, Oosterhoff, Hill, & Pynoos, in press; Salloum, 2008).

The general literature on bereavement trauma (e.g., Ehlers & Clark, 2003) notes that individuals are likely to adjust without requiring professional support. However, homicidally bereaved individuals seem to report more severe mental health issues for a long period of time when compared to individuals who have been through different traumatic experiences or 'normal losses' (e.g., Bonanno & Kaltman, 2001) across time. One possible factor to consider is the manner in which the bereavement occurred.

Recent worldwide figures[24] (UNODC, 2017) demonstrate that 262,772 people were killed in 2015 by homicide, with each of those having usually left multiple individuals behind at risk of maladjustment post-experience. Prolonged and chronic effects are often reported, such as post-traumatic stress responses, depression and complicated grief (e.g., Amick-McMullan et al., 1989; Armour, 2002; Baddeley et al., 2015; Currier et al., 2006; Rheingold & Williams 2015; Rheingold et al., 2012; Shear, Frank, Houck, & Reynolds, 2005; van Denderen et al., 2014). The unique elements that characterise a death by homicide seem to increase the likelihood of more severe difficulties post-bereavement, namely the sudden, unexpected and violent nature of the event, the protracted legal processes, as well as the dual private and public nature of the grief, such as media coverage and court cases (*names removed for masked review, in submission*). This has been shown to occur at all ages. Younger children may develop severe psychopathology, such as symptoms of PTSD and ongoing maladjustments following violent deaths (e.g., Freeman, Shaffer, & Smith, 1996; Salloum, 2008). For adolescents, the impact of a traumatic bereavement can lead to serious developmental

[24] Figures should be conducted with caution due to the dissimilar legal definitions of offences across countries, as well as different methods of offence counting and recording.

implications, such as alcohol and drugs consumption, increased impulsivity, engaging with risky behaviour and impaired executive functioning skills (Layne et al., in press).

Research on traumatic bereavement (e.g., following a homicide, suicide, vehicle accident) has been increasing in the few last decades (e.g., Murphy, Chung, & Johnson, 2002; Prigerson 2004). Alongside that has been a rise in the professional support available for those individuals. Trauma and grief-focused interventions, for instance, have been gaining popularity among individuals traumatically bereaved (for adults, children and adolescents).

Overall, trauma-focused research for adults has demonstrated that early trauma intervention (immediately after the traumatic event, one-session debrief with CBT or psychoeducational elements) might *not* be effective at preventing traumatic symptoms. However, longer courses of CBT sessions have a good evidence base for positive treatment outcomes (e.g., Ehlers & Clark, 2003). More recent findings show that trauma-focused cognitive behavioural therapy (TF-CBT; see Cohen et al., 2006) has become the most common treatment for children and adolescents who been been through a traumatic experience (Cohen et al., 2010). Yet, for adults, the better evidence-base is for cognitive-behavioural therapies, including prolonged exposure, cognitive processing therapy, cognitive therapy for PTSD, and EMDR, as well as elements of CBT including exposure and cognitive restructuring (Schnurr, 2017).

Regarding potential moderators of psychopathology (i.e., time since loss, relationship with the victim, witnessing (or not) the event) previous studies found mixed results. For example, some found non-significant effects of time since loss and treatment outcome for PTSD and Complicated Grief (CG; Rheingold et al., 2015; Salloum et al., 2001; Salloum, 2008). Participants who reported a more *positive* relationship with the deceased has been associated with greater post-treatment symptom severity (Asukai et al., 2011; Rheingold et al., 2015), but the actual relationship to the

deceased (i.e., parent, sibling) did not impact the treatment efficacy where mothers who had lost a child showed as much improvement as those who had experienced the loss of other loved ones (Asukai et al., 2011). Overall, however, there are no interaction effects of time (pre and post-treatment) by type of relationship (child vs no child) for depression, CG, PTSD, intrusions or arousal (Rheingold et al., 2015).

Similarly, children who witnessed the homicide and/or aftermath reported initially higher levels of posttraumatic symptoms; 41% (n=15) of those children who remained in the clinical range of symptoms on the post-treatment had witnessed. However, there was no statistically significant results between pre- and post-test, and proximity (witness and non-witness; Salloum 2008). Finally, Rheingold et al. (2015) found non-significant interaction effects of time (pre- and post-intervention) by type of death (i.e., homicide, suicide accident and multiple/different types) for depression, overall PTSD and complicated grief symptoms. However, homicidally bereaved individuals had higher PTSD symptoms, avoidance (p=.024) and hyperarousal compared with those grieving following suicide or accident.

With reference to homicidal bereavement experiences in particular, a systematic review (*names removed for masked review, in submission*) found that limited research has been conducted to estimate the efficacy of psychological interventions for homicidally bereaved children, adolescents and adults. Despite that, the review noted that the main psychological models of intervention that have been subject to some evaluation seem to benefit individuals; all were group interventions, with group size ranging from six to 13. Duration and frequency of the interventions varied and the models included: cognitive behavioural therapy (CBT); restorative retelling intervention (RR); residential psychoeducational retreat; and CBT with psychoeducational and grief elements. In summary, the systematic review concluded that both CBT and RR with psychoeducational and grief elements seem to be effective for supporting homicidally

bereaved adults generally, but also specifically beneficial for decreasing PTSD symptomatology post-treatment. Furthermore, there is evidence for group interventions for children and adolescents (Salloum et al., 2001; Salloum, 2008). However, the systematic review was not able to identify what components of treatment are crucial or expendable (e.g., psychoeducation, exposure, emotional expression, cognitive or meaning-oriented interventions, coping, resilience and positive change/growth) due to the limited number of studies included.

Residential psychoeducational interventions offer a unique holistic framework to support individuals. Most include psychoeducational models focusing on psychological impact(s), legal experiences and coping-skills (e.g., Tuck et al., 2012; Support after Murder & Manslaughter (SAMM) in the UK; the Aurora Family Therapy Centre in Canada; and the National Organization of Parents of Murdered Children in the United States of America). However, to date, limited research has been conducted to demonstrate the effectiveness of residential interventions.

Therefore, as part of a wider longitudinal mixed methods approach project, the present study sought to understand longitudinal outcomes following homicidal bereavement, including following a four-day residential psychoeducational group intervention offered by a UK charity Escaping Victimhood; EV. More specifically the research aims were to:

1. Understand what psychopathology was more commonly reported pre-intervention;
2. Evaluate the progression of clinical symptoms (post-intervention, follow-up I and II);
3. Understand coping and resilience trends (before and after the EV intervention); and,

4. Estimate if the relationship with the victim and offender, as well as time since loss predict
    4.1. Individual's (mal)adjustment (lower vs higher scores) at pre-intervention; and,
    4.2. Intervention outcomes following the EV intervention.

Specifically, the following hypotheses were considered:

1. Homicidally bereaved individuals will report high levels of psychological difficulties (measured[25] by the BSI, PDS and PG-13) at baseline, but these will decrease post-intervention, at 6 weeks and at 9 months.
2. Homicidally bereaved individuals will have low levels of resilience and coping (measured by CD-RISC and CRI), at baseline, but these will increase post-intervention, at 6 weeks and at 9 months.
3. Close relationship with the victim (e.g., parents vs. non-parents and knowing the offender, as well as time since loss will impact on the psychopathology levels and its progression over time.

Context: Escaping Victimhood

EV offers[26] a four-day residential & experiential intervention across the UK for those affected by serious crime, including homicide. The interventions are funded by different organisations covering the costs associated with the intervention (i.e., accommodation, subsistence, travel expenses, meeting rooms and facilitators). Individuals can be referred (e.g., medical practitioner, Victims Support services) or self-refer and usually attend post-trial. EV participants are often individuals that seem to have ongoing difficulties, demonstrating particular difficulty coping (even when they have been supported by other national services). In fact, pre-intervention assessments

[25] Information about the measures used can be find in the *Methodology* section.

[26] More information about the EV programme can be find on their website: http://www.escapingvictimhood.com/.

demonstrated that individuals reported symptoms considered clinically significant for PTSD, grief responses and overall mental health.

In addition to the residential workshops, a one-day (non-residential) follow-up is held six to eight weeks after each residential workshop[27]. It should be noted that individuals are referred into an EV programme have usually received significant input from other services (including Victim Support) but continue to have significant ongoing difficulties.

EV takes a holistic approach to the mental health effects of a trauma event by delivering an informative workshop about traumatic experiences alongside creative and relaxing activities. The psychoeducational workshops focus on the potential impact following a traumatic event, namely the psychological, family, social and professional effects. On the other hand, EV workshops focus on coping resources that may help individuals to find ways forward. In addition, their holistic philosophy incorporates experiential activities such as photography, art and therapeutic massages to promote wellbeing and reinforce the practice of new activities following the intervention.

The multidisciplinary team consisted of probation officers, restorative facilitators, trauma experts and psychologists; during the data collection process the core team remained the same but there was some variation in the wider team (i.e., in psychologists). However, new facilitators were trained with the more senior members of the team prior to any workshop.

Method

Ethics

This study (and the wider mixed methods studies) received ethical approval from the Psychology Ethics Committee at the University of Bath (Ref. 14-186) and met

27 The one-day follow-up aimed to listen to individual's perceptions about the EV programme. Therefore, data was not collected, in order to avoid possible bias.

standards set by Escaping Victimhood. In addition, British Psychological Society and Health and Care Profession Council ethical guidelines were followed.

Sample

Sixty-seven participants (predominantly female [n=64], White UK[28], of relatively low to medium income and with mixed occupation status) took part in the study at pre-intervention assessment, 61 at post-intervention (91% retention), 37 at follow-up I (55%) and 33 at follow-up II (49%) aged 18-75 years (*M*=48.71 (*SD*=12.14).

In summary, more than half were on long term medication (e.g., for depression, for anxiety, and some were taking sleeping pills). A minority had a past history of receiving interventions for psychological difficulties specifically, but the vast majority had some kind of support in the past (e.g., GP, police, victims support services). In terms of legal classification of type of homicide, murder was the most frequent act among this sample and occurred mainly from 12 months to 10 years prior to the data collection. For the majority, the offender was unknown and participants were mainly the parents of the victim (half of the sample). Table one provides more information about the participants' demographic, medical and contextual information by time-point.

[28] The most recent Census in 2011 highlights that in England and Wales, 80% of the population were white British.

Table 1. Demographic, medical and contextual information by time-point.

	Baseline (N=67) n %	**Post-intervention (N=61)** n %	**Follow-up I (N=37)** n %	**Follow-up II (N=33)** n %
Gender	59. (88.1)	54 (88.5)	33 (94.3)	28 (87.05)
Female				
Age [mean (SD)]	48.71 (12.14)	49.03 (12.09)	50.97 (10.83)	46.45 (12.91)
Ethnicity				
White	52 (82.5)	50 (83.3)	27 (79.4)	26 (83.9)
Black other	5 (7.9)	5 (8.3)	4 (11.8)	2 (6.1)
Other	5 (7.9)	5 (8.3)	3 (8.8)	3 (9.7)
Marital Status				
Relationship	25 (44.6)	25 (45.5)	15 (50.00)	12 (42.9)
No relationship	31 (55.4)	30 (54.5)	15 (50.00)	16 (57.1)
Religion				
No religion	13 (24.1)	13 (25.0)	5 (18.5)	6 (22.2)
Christian	34 (63.0)	32 (61.5)	18 (66.7)	17 (63.0)
Other	7 (10.4)	(13.5)	4 (14.8)	4 (14.8)
Education				
No qualifications	4 (6.7)	4 (6.9)	3 (9.4)	3 (10.3)
Secondary	27 (45.0)	27 (46.6)	15 (46.9)	9 (31.0)
Tertiary education	28 (46.7)	27 (46.6)	13 (40.6)	17 (58.6)
Other	1 (1.7)	-	-	-
Occupation status		29 (50.0)	15 (48.4)	17 (58.6)
Employed	30 (49.2)	29 (50.0)	16 (51.6)	12 (41.4)
Unemployed	31 (49.2)			
Income			3 (14.3)	6 (31.6)
Low	12 (26.3)	12 (26.3)	14 (66.7)	9 (47.2)
Medium	20 (52.6)	20 (52.6)	4 (19.0)	4 (21.2)

High	8 (21.1)	8 (21.1)		
Long-term medication	39 (58.2)	37 (61.7)	21 (61.8)	17 (45.2)
No Psychological support				
Present	46 (71.9)	42 (70.0)	22 (64.7)	22 (71.0)
Past	43 (71.7)	41 (73.2)	26 (78.8)	29 (93.5)
No drugs or alcohol abuse	55 (87.3)	52 (88.7)	31 (93.9)	29 (93.5)
Homicide				
Murder	55 (82.1)	51 (83.6)	27 (73.00)	27 (81.8)
Time since loss				
>12 months	59 (92.2)	55 (93.2)	30 (85.7)	27 (87.1)
Offender				
Unknown	30 (52.6)	27 (50.9)	14 (43.8)	13 (46.4)
Known	27 (47.4)	26 (49.1)	18 (56.3)	15 (53.6)
Relationship with victim				
Parents	34 (52.3)	32 (53.3)	21 (60.00)	16 (50.00)
No parents	31 (47.7)	28 (46.7)	14 (40.00)	15 (50.00)
Agencies involved[29]				
Yes	64 (98.5)	60 (100.00)	34 (97.1)	32 (97.00)

Note: Information was collected at pre-intervention. Values might vary due to missing data.

Recruitment

Participants were recruited from eight residential intervention groups run by EV (selection for the EV residential programme itself was done by the EV team). Therefore, this study used a convenience sampling method. Overall, 74 individuals took part in those eight groups, of which 68 individuals[30] (91%) agreed to take part in the research.

The eight programmes ran between September 2014 and October 2016. Individuals were invited to take part in this study on day one of the programme they attended. Inclusion criteria were pre-established as: a) a family member or a close friend to an individual killed by homicide (murder or manslaughter); b) aged 18 years or older

[29] Agencies involved included GPs; Victim support and Homicide services; SAMM.

[30] One participant was excluded from the analyses as he/she dropped-out at the beginning of one of the EV interventions.

when the interview was conducted; and c) to have experienced the loss at least nine months prior to the data collection.

In addition, a call for volunteers was launched through the local and national media in the UK (i.e., supported by the media services at the University of Bath and College of Policing). This aimed to establish a comparison between homicidally bereaved individuals that attended to the EV intervention and a community sample. Unfortunately, this strategy was unsuccessful and recruitment in the community discontinued.

Procedure

'Face-to-face' assessments occurred during the four-day EV intervention. Individuals were assessed pre and post-intervention. Subsequent follow-ups were conducted by post. The postal pack included a pre-paid envelope and a cover follow-up letter. In order to keep response rates as high as possible, a telephone call and/or other reminders (letters, texts, emails) were used as a strategy, as suggested in the literature (Baolley, Kral, & Dunham, 1999). However, when it had not been possible to contact an individual after five attempts, contact was discontinued to ensure best practice and follow ethical guidelines.

Materials

This research used structured validated self-report questionnaires (with psychometric proprieties from high to excellent) to estimate psychopathology, coping, resilience and group environment perceptions (see Table 2 for full details):

- Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983)
- Posttraumatic Stress Diagnostic Scale (PDS; Foa, Cashman, Jaycox, & Perry, 1997)
- Prolonged Grief Disorder-13 (PG-13; Prigerson et al., 2009)
- Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003)

- Coping Resources Inventory (CRI; Marting & Hammer. 2004) and,
- Group Environment Scale - Form R (GES; Moos, 1994, 2002).

As part of the analysis, test retest reliability analyses were performed on all four time-points in this study for each questionnaire. Cronbach's α ranged from .67 to .97 (i.e., high to excellent). Furthermore, additional information (i.e., demographics, medical and contextual background) was requested using a questionnaire developed and piloted by the authors.

Table 2. Summary of the included measure.

	Brief description
BSI	Measures nine clinical dimension (somatisation, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and, psychoticism). Global Severity Index scores range from zero to 100 (higher scores represent greater severity) with a cut-off point of 50 and a standard deviation of 10.
PDS	Aids in the detection and diagnosis of posttraumatic-stress disorder (PTSD) using DSM-IV® diagnostic criteria for a PTSD diagnosis. The PDS includes a symptoms severity score which ranges from zero to 51. The cut-offs for symptom severity rating are 0 no rating, 1–10 mild, 11–20 moderate, 21–35 moderate to severe and, >36 severe.
PG-13	It is a diagnostic tool for prolonged grief disorder. A total score can be computed ranging from zero to ten (higher scores reflect more elevated symptoms of prolonged grief).
CD-RISC	Accesses levels of adult resilience with total scores ranging zero and 100 (higher scores represent greater resilience).
CRI	Measures coping resources in five domains (cognitive, social, emotional, spiritual/philosophical, and physical). Total scores ranging from zero to 100 with a cut-off point of 50 and a standard deviation of 10 points (higher scores represent greater coping resources).
GES	Measures participants' perceptions of a group according to nine different subscales (cohesion, leader support, expressiveness, independence, task orientation, self-discovery, anger and aggression, order and organization, leader control and, innovation). Scores range from zero to 80 with a cut-off point of 50 and a standard deviation of 10 points (higher scores represent greater perceptions).

Data analytic plan

The normality assumption was checked using the Shapiro-Wilk test. Data exploratory analyses demonstrated that data was non-normally distributed, as is frequently found in social and clinical studies. A computerised statistical package (IBM SPSS, version 22) was used to analyse the data.

Multi-wave studies are likely to present sample attrition, and this might increase attrition bias due to systematic attrition (see Little & Rubin, 2002). Therefore, a missing-ness pattern was analysed (Asendorpf, Schoot, Denissen, & Hutteman, 2014). The results of Little's MCAR (Missing Completely at Random) test demonstrated that data were *not* completely missing at random' (known as MAR) for the two scales at follow-up I and II ($p < .05$). For that reason, systematic selective attrition analyses were performed by comparing the drop-outs with the continuing participants at all time-points for the BSI and coping resources measures (as suggested in the literature, Rubin, 1987). Independent-samples t-tests demonstrated that there were no significant differences in total scores for participants and drop-outs at all assessments. In other words, the systematic attrition was not significant ($p > .05$). Furthermore, for the remaining outcomes (PTSD, complicated grief, resilience and group environment), data *were* missing completely at random (MCAR; $p > .05$) with this indicating that systematic attrition does not occur (Little & Rubin, 2002). Consequently, it was not necessary to perform selective attrition analyses (Asendorpf et al., 2014).

Descriptive statistics were used to describe the sample (e.g., demographic information, medical background, event, victim characteristics, age, and support post-homicide). Furthermore, measures of central tendency (means, *SD*) were used to estimate mean scores across time (i.e., from pre-interventions to post-interventions and follow-ups). Data assumed a hierarchical structure, therefore multilevel modelling for repeated measures (Linear Mixed Models – LMM; Raudenbush & Bryk 2002;

Söderfeldt et al., 1997) was used to examine the intervention effectiveness over time, as well as tests predictors. Furthermore, using this type of modelling prevented Listwise deletion due to missing data, which is more common in multi-wave studies such as this. In fact, multilevel modelling are increasingly popular models to analyse multiple waves studies, offering more robust alternatives to ANOVAs, for example.

Table 3. Psychopathology, resilience and coping progression.

		Baseline (N=67) n %	Post-intervention (N=61) n %	Follow-up I (N=37) n %	Follow-up II (N=33) n %
Psychological symptoms (BSI)					
	>50	67 (100)	57 (93.0)	32 (64.4)	27 (81.8)
	<50	-	4 (7.0)	5 (35.6)	7 (18.2)
PTSD (*PDS*)	**>15**	56 (83.58)		26 (70.27)	25 (75.75)
	<15	5 (16.42)	-	11(29.73)	8 (24.25)
Grief responses (*PG-13*)	**>5**	67 (100)		20 (54.05)	23 (69.70)
	<5	-	-	17 (45.95)	10 (30.30)
Resilience (*CD-RISC*)	**>50**	44 (65.68)		21 (56.75)	17 (51.51)
	<50	23 (34.32)	-	16 (43.25)	16 (48.48)
Coping (*CRI*)					
	>50	6 (10.45)		4 (10.82)	8 (24.25)
	<50	60 (89.55)	-	33 (89.18)	25 (75.75)

Models were created for each of the intervention outcomes (i.e., psychopathology, PTSD, grief, coping and resilience). The five models were built in stages, starting with a creation of null models (models 'without predictors') and successively adding in the fixed effects (i.e., time) and random effects (e.g., relationship with the victim, offender and time since loss), as is recommended (e.g., Heck, Thomas, & Tabata, 2014). 'Best-fit model' was selected by choosing the model with the lowest likelihood ratio test (LRT; Ryoo, 2010).

Results

Baseline frequencies

As would be expected given the criteria for referral to an EV programme, at baseline, all participants were experiencing high levels of psychological difficulty and had low rates of positive coping (see Table 3). However, in contrast, there was a relatively high rate of resilience. Figures 1a-e show the progression of mean scores.

Outcomes over time

Mean scores for outcomes at the three (PTSD, CD-RISC, PG-13, CRI) or four[31] (BSI) different time points are shown in Figures 1a-e. Overall, they all showed reductions, some of which were statistically significant.

Psychological symptoms (BSI). All participants reported clinical symptomatology (scoring >50) at all-time points. However, inspection for means values demonstrated an overall decrease in BSI total mean scores from pre-intervention (*M*=73.92, *SD*=7.85) to post-intervention (*M*=68.75, *SD*= 10.17), follow-up I (*M*= 68.55, *SD*= 11.87) and, to follow-up II (*M*= 65.55, *SD*=11.40). Further, there was a significant interaction of time on the BSI total scores ($F(3,193) = 6.00$, p=.001). Pairwise comparisons showed a significant decrease of BSI symptoms from pre-intervention to post-intervention ($t(192) = -2.87$, p=.004) and to follow-up II ($t(192) = -$

[31] EV had concerns about the level of testing. Therefore, participants were only asked to complete one measure post-intervention (BSI) following EV's suggestion.

3.88, p=.000). Furthermore, there was a marginal significant decrease from pre-intervention to follow-up I (*t*(192)= -2.62).

PTSD. The majority of participants met criteria for PTSD according to the DSM-V (scoring >15) at all time-points. There was a significant impact of time on the PTSD symptoms (*F*(2,122)= 3.48, p=.034). However, mean scores presented an overall trend to decrease from pre-intervention (*M*=34.30, *SD*=11.88), to follow-up I (*M*=28.18, *SD*= 14.29) and II (*M*=27.59, *SD*=15.74).

Grief Symptoms. Participants' mean score for clinical grief was high at pre-intervention (scoring >5) and moderate at both follow-ups (mean=5; range = 3-5). Mean scores decreased from pre-intervention (*M*=6.84, *SD*= 2.79) to follow-up I (*M*=4.92, *SD*= 3.56), and II (*M*=4.51, *SD*=2.72). Results demonstrated that there was a significant decrease in grief symptoms across time ((*F*(2,97)= .4.58, p=.013).

Resilience. Individuals reported satisfactory levels of resilience (scoring >50) at all time-points. Inspection of mean scores demonstrated a slight decrease in total means scores from pre-intervention (*M*=54.39, *SD*= 16.85) to follow-up I (*M*= 53.31, *SD*= 18.41) but an increase again at follow-up II to above baseline rate (*M*=55.39, *SD*=13.81). However, this was a non-significant increase in resilience scores across time (*F*(2,129)= .199, p=.820).

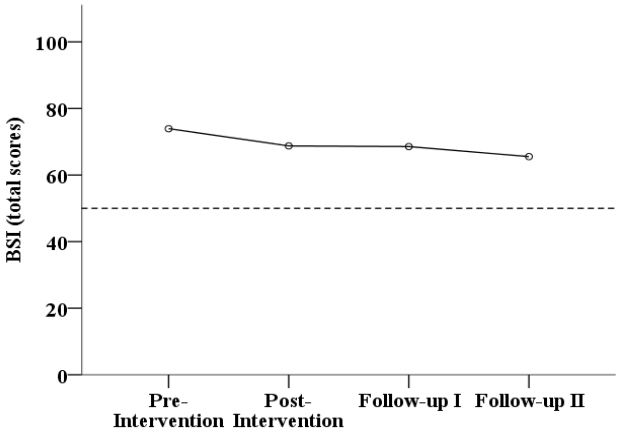
Coping resources. Overall, participants demonstrated low coping resources mean scores (scoring <50) at all time-points. Inspection of mean values demonstrated an overall slight increase from pre-intervention (*M* = 34.11, *SD*= 12.64) to follow-up I (*M*= 34.94, *SD*= 12.84) and again to follow-up II (*M*= 38.31, *SD*=15.06). However, this was a non-significant increase in total scores from baseline to follow-ups I and II (*F*(2,119)= 1.08, p=.343). Regarding the different coping domains assessed, there were non-significant differences across time, with the exception of the cognitive and

emotional domains that increased significantly from follow-up I to follow-up II ($p < .005$).

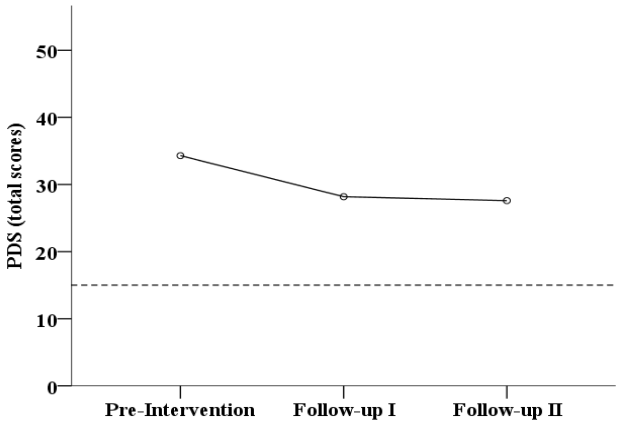
Effects of symptomatology on the intervention outcomes

Relationship with the victim and offender, as well as time since loss did not predict (lower or greater) symptoms at baseline ($p > .05$). Furthermore, those same independent variables did not predict the intervention outcomes at post-intervention, neither at follow-up I and II (minimum $p > .05$).

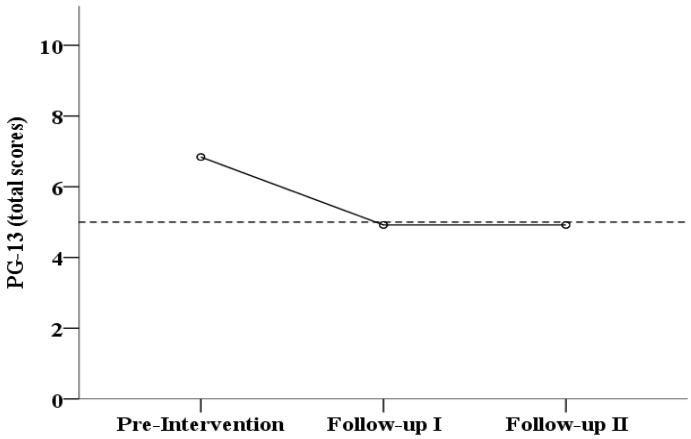
a) *Overall psychopathology*.



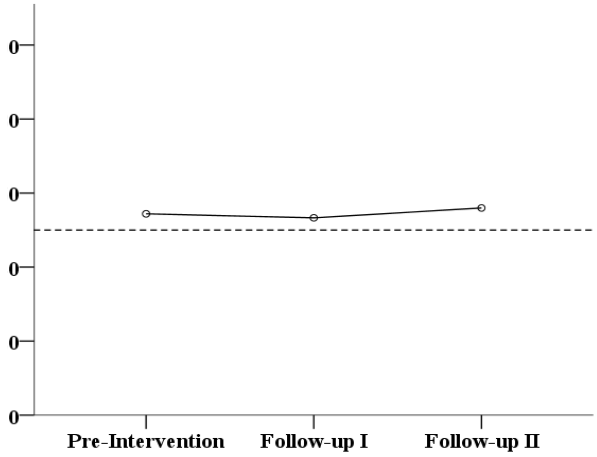
b) *PTSD patterns*.



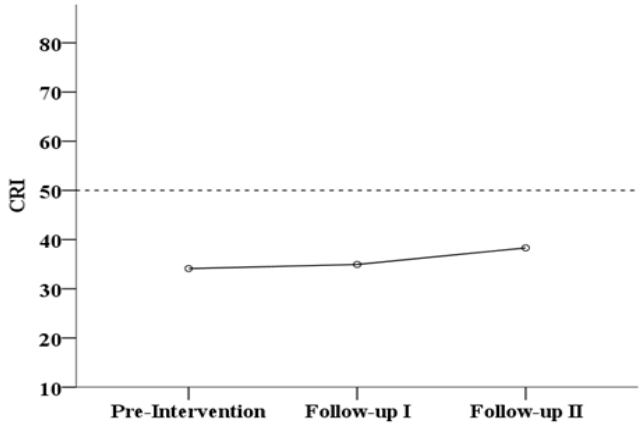
c) *Grief responses*.



d) *Resilience trends*.



e) *Coping patterns*.



Figures 1a-e. Mean scores at all-time points (baseline, post-intervention (for BSI) and follow-ups 1 (6 weeks) and II (6 months)).

Group Environment

Finally, participants (n = 50) [32]the across eight different groups completed a measure to assess their perception about the group environment (at the end of the intervention). The Group Environment Scale (GES) incorporates ten subscales related with different dimensions, mainly: relationship (cohesion, leader support and expressiveness), personal growth innovation (independence, task orientation, self-discovery and anger and aggression), and system maintenance and change (order and organisation, leader control and innovation).

The vast majority of the participants perceived their groups as cohesive, supportive and encouraging individual's expression of affect, focused on task-orientation, self-discovery and, independence (Figure 2). Furthermore, individuals rated the group as orderly and well structured, innovative with the leader having an important supportive role, as well as control (range of mean scores: 44.50 (*SD*=6.61) - 59.75 (*SD*=6.06)). Overall, participants experienced a good group environment during the EV programme, which is likely to be a crucial pre-condition for improvement. Importantly, analyses were also performed to consider each of the eight groups separately to estimate potential divergences. However, mean scores did not differ significantly.

Figure 2.Group environmental assessment.

[32] The Group Environment Scale (GES) was only responded by 50 individuals, because this measure was not considered from the beginning of the data collection process.

EV specifics. The experiential components of the EV intervention were not formally assessed in this study (therapeutic massages, photography and art sessions). However, the qualitative studies conducted with 46 participants demonstrated high levels of satisfaction with those activities (*names removed for masked review, in submission*) and several referred to them as new coping strategies. Similarly, for the vast majority of the individuals, the residential nature of the EV intervention was seen as an important element that contributed to their overall wellbeing.

Discussion

This study aimed to evaluate the longitudinal outcomes for individuals following homicidal bereavement, following their attendance at a four-day psychoeducational group intervention. It was hypothesised that intervention outcomes (i.e., psychological maladjustment, PTSD, complicated grief) would decrease, and that resilience and coping patterns would improve over time following the EV intervention. Finally, the relationship with the victim and offender, as well as time since loss was considered in terms of maladjustment at pre-intervention and relationship with intervention outcomes.

The findings support previous research that a large percentage of homicidally bereaved individuals show severe psychopathology post-homicide (e.g., Rheingold & Williams 2015; Rheingold et al., 2012; Rheingold & Williams, 2015; van Denderen et al., 2014). In the current study, prior to their attendance at the residential intervention, the majority of individuals received professional support post-loss (not necessary psychological interventions) and had been offered a variety of support from different services. Nevertheless, participants' reported moderate to high clinical symptomatology at all time-points, including baseline.

Results from this study appear to be encouraging though.

Hypothesis 1: There will be a reduction in psychological difficulties post-intervention and at follow-ups

Psychological difficulties. The first hypothesis that psychopathology (measured by BSI) will decrease over time was supported. On the BSI, some subscales (i.e., depression, anxiety, hostility, phobic anxiety and psychoticism) showed greater mean reductions (4-10%) than the other sub-scales. In terms of comparison with other research, to the authors' knowledge, there are no studies using the BSI to measure clinical (mal)adjustment for homicidally bereaved individuals. Therefore, direct comparison between interventions models cannot be made. However, previous studies

conducted with adults post-homicide have estimated depressive trends (one of the BSI sub-scales). Generally, depressive symptoms decreased at post-intervention and follow-ups with interventions such as Restorative Retelling (RR; Rheingold et al., 2015; Saindon, et al., 2014), CBT traumatic grief approach (Asukai et al., 2011), and a two-day retreat (Tuck et al., 2102). All had psychoeducational elements. Notably, in all those studies, there were fluctuations of depressive symptoms between waves (i.e., pre-intervention, post-intervention and subsequent follow-ups); this highlights the importance of conducting longitudinal studies (with multiple follow-ups). In fact, a recent systematic review noted that clinical trials tend to present short follow-up periods, (two years or less). This may underestimate potential benefits of the intervention, as well as potentially fail to detect vulnerabilities/risks (Llewellyn-Bennett & Bulbulia, 2016). Furthermore, a review looking at efficacy and acceptability of psychological interventions for depression (Hollon, 2016) demonstrated that individuals with less severe depression are likely to respond to a variety of interventions, but those with more severe depressions might require more specific elements to the intervention.

PTSD. In this study, the vast majority of the participants reported severe levels of PTSD (scoring >15) at all time-points. However, PTSD symptoms did decrease over time. Similarly, other studies demonstrated that psychological interventions with RR, CBT combined with psychoeducational elements were effective at decreasing traumatic responses post-homicide (e.g., Asukai, et al., 2011; Rheingold et al., 2015; Saindon et al., 2014; Tuck et al., 2102). More broadly, research on different potential traumatic/violent experiences suggests that different models of intervention appear to be effective to treat PTSD, such as CBT, eye movement desensitization and reprocessing (EMDR; Seidler & Wagner, 2016). Another study testing the efficacy of trauma management therapy (Beidel, Frueh, Neer, & Lejuez, 2017) reported encouraging results from a three-week intensive outpatient program for combat-related PTSD

(65.9% of patients no longer met diagnostic criteria for PTSD. Results were maintained at 6 months follow-up). Thus, interviewing on traumatic responses might include additional psychological techniques for an optimal result.

Grief. Finally, moderate to high grief responses were reported by the participants with mean scores statistically decreasing over time which indicates diminished grief responses following the EV intervention. Previous studies with homicidally bereaved individuals have described significant decreased grief responses following psychological interventions with RR elements (Rheingold, 2015; Saindon, 2014), and a traumatic grief treatment with a CBT approach (Asukai et al., 2011). Finally, a two-day retreat has described decreased mean scores on grief responses (Tuck, et al., 2012). Overall, results from treatment studies with mixed samples (not necessarily with homicidally bereaved individuals) suggest that complicated grief interventions with cognitive, exposure, restructuring, and interpersonal elements are as effective at decreasing prolonged grief symptoms (e.g., Boelen, de Keijser, van den Hout, & van den Bout, 2007; Bryant, Kenny, Joscelyne, 2014; Shear et al., 2005; Supiano, 2014). Moreover, a study that combined psychological with pharmacological support registered a better result (i.e., greater decreasing of grief symptoms over time; Shear et al., 2016).

Hypothesis 2: Participants will show increased resilience and coping following intervention

Resilience. Results from the current study revealed that individuals reported reasonably high levels (scoring >50) of resilience at all time-points, including baseline. Hence, the change was non-significant and hypothesis two (part 1) was rejected.

The initially quite high rates of resilience in this groups is interesting, particularly given that the individuals referred to EV are those who had ongoing needs over and above the previous support they had been offered, which were often quite

extensive (e.g., Victim Support) and who had high levels of psychopathology at baseline. Although there is limited research estimating resilience among homicidally bereaved individuals, it has been noted that maladaptation is only one possible outcomes following many forms of trauma (Futa, Nash, Hansen, & Garbin, 2003) and some individuals demonstrate an overwhelming ability to cope and show resilience (Kalisch, Muller, & Tuscher, 2015; Mancini & Bonanno, 2009). Interestingly, therefore, this group is both showing moderate to high levels of psychological difficulties but also some level of resilience.

In terms of interventions, a recent systematic review on psychological interventions for resilience enhancement in adulthood shows that there are still little consensus about resilience training but that new problem solving strategies can be beneficial for wellbeing and adjustment following a traumatic experience (Vanhove, 2015). This is another avenue to consider.

Coping. Regarding coping responses, participants showed mainly low to medium resources at all three time-points (scoring <50). Inspections for mean scores revealed a trend to slightly increase across time, with this representing an improved coping resources following the EV intervention. Hence, hypothesis 2 (part 2) has been accepted. Looking at the sub-elements, both cognitive and emotional domains of coping significantly increased from follow-up I to II. This informed about the individuals' increased resources post-intervention and suggested that coping-focused training among those individuals is crucial.

Previous research has found that formal and informal experiences of support are found to impact adjustment (O'Dougherty-Wright & Masten, 2004). With a sub-group of participants from this study, qualitative interviews (*names removed for masked review, in submission*) revealed that EV participants had mixed experiences of prior support, both formal and informal. The majority of them reported having been

professionally and informally supported, but that support was not always perceived as effective/enough. This was mainly due to the intervention time frames (formal support from some organisations can end when the legal processes are concluded), as well as the individual's perception of not being fully understood by practitioners and relatives who have not been through similar bereavement experiences. Whilst not an uncommon response from individuals with mental health difficulties, clearly personal prior experience is not a pre-requisite to providing good therapeutic support.

In terms of type of coping, a qualitative study conducted with eight African American homicidally bereaved individuals (Sharpe & Javier Boyas, 2011) demonstrated that spiritual coping and meaning making, maintaining a connection to the deceased, collective coping and caring for others, and concealment were the most frequent coping strategies reported. Englebrecht, Mason and Adams (2016) demonstrated that individuals identified that support (both formal and informal) was important as a coping mechanism. Additionally, the same study reported that 'creating distance' and substance abuse were also negative strategies mentioned. Finally, another qualitative study (*names removed for masked review, in submission*) demonstrated that individuals appear to benefit from getting information about their psychological responses, i.e., normalising the grief reaction. Importantly, the fact that cognitive and emotional domains of coping significantly increased across time in this study, which highlight that *time* might also be an important element to consider following interventions, as the development of 'new-selves' and changed coping responses is likely to not occur immediately after. Hence, to determine if this relates to the intervention or just time requires the use of a control group.

Hypothesis 3: Outcomes will be affected by relationship with victim and offender, and time since loss

Regarding potential predictors, non-conclusive results were found: relationship with the victim, offender, and time since loss did not predict either (greater or lower) psychopathology at baseline or the interventions outcomes (better vs worse adjustment). Similarly, other studies found no interaction effects of time (pre and post-treatment) by type of relationship (child vs no child) for depression, complicated grief, PTSD, intrusions or arousal (Rheingold et al., 2015). On the contrary, more positive relationships with the victim (not measured in our study) were associated with greater complicated grief and hyperarousal symptoms post-treatment (Asukai et al., 2011; Rheingold et al., 2015). Moreover, time since loss did not predict intervention-outcomes in previous studies (Rheingold et al., 2015; Salloum et al., 2001; Salloum, 2008). Furthermore, a previous study with a mixed sample (individuals were grieving from different types of violent deaths) concluded that homicidally bereaved individuals had higher PTSD symptoms compared with those grieving following suicide or accident. Future research should explore these dissimilarities further.

EV specifics

In addition to the highlighted results, participants reported positive satisfaction [33]with the groups, peers, facilities, and EV team of facilitators and leaders. The experiential activities (therapeutic massages, photography and art sessions) were also very well rated. Furthermore, qualitative elements of this project (*names removed for masked review, in submission*) demonstrated that some individuals continued to find ways of accessing these activities post the residential group and described them at follow-up as "*new activities*" and "*new coping strategies*". Moreover, the residential nature of the EV programme was described as beneficial.

In summary, participants showed significant reductions in psychological difficulties and increased coping following this four-day residential programme. Such

[33] The qualitative element of this research informed about the participant's perception.

changes are notable given that the individuals attending had unmet needs following other interventions. It would be interesting to undertake a longer term follow-up, for example 2-5 years later. Indeed, a qualitative study has retrospectively interviewed prior participants to gain their perspective of change (or not) in that timeframe (see *names removed for masked review,* in preparation), and identified participants viewed the psychoeducation as a crucial element for better coping/self-positivity post-intervention. However, it would be useful to extend the current prospective, longitudinal study reported in this paper to provide quantitative data to supplement that qualitative methodology.

Strengths and limitations

This study followed a rigorous longitudinal methodology, confirming and extended other studies conducted previously. Longitudinal studies are likely to present sample attrition and, for that reason, the missing-ness pattern was analysed to control attrition bias and robust multilevel modelling were performed to address the research questions (rather than ANOVAs).

Despite the positive contributions of this study, there were limitations. In particular, the considerable small sample size (especially at the follow-ups). In addition, a significant limitation was the lack of control group. A larger sample drawn from a broader range of those who have been homicidally bereaved (but who either did not meet thresholds to be referred to residential programmes or lived in an area where services choose not to refer in to EV) could potentially add more information. Efforts to recruit such a sample were unsuccessful on this occasion and led to too few participants to be meaningfully analysed. Therefore, it was not possible to establish comparisons between individuals with EV and non-EV experience. In addition to that, follow-ups were no longer than 12 months and therefore more longitudinal changes (positive or negative) were not identifiable. Despite the valuable information retrieved from the two

follow-ups, an extended period of follow-up period could have added more information about possible fluctuation of psychopathology, coping and resilience trends. Finally, the sample was predominantly female, therefore it was not possible to estimate possible differences between genders.

Clinical implications

Results are likely to inform future clinical practice, in terms of confirming that such individuals have ongoing intervention needs and highlighting elements that are likely to help individuals to adjust (e.g., knowing more about emotional and psychopathological responses, new coping strategies). The development of a clear protocol regarding the type and avenues of support for homicidal bereaved individuals would assist in ensuring individuals receive the help they require, including the development of a rigorous assessment tool where potential protector and risk factors could be identified. In other words, standardised questionnaires and clinical interviews could be made available among the UK professionals working with homicidally bereaved individuals, as this could facilitate the referral process. This plan could be developed and managed by experienced professionals who work for the national homicide service together with UK research teams researching homicidal bereavement experiences. This would be in line with some of the recommendations made by Casey (2011).

A structured '*plan of action'*, as well as individual formulations that can be performed by non-psychologists could then be formulated according to the individuals' needs at that specific time-point, given that this and the wider mixed methods study have shown that needs immediately post-homicide, during the legal procedures, and before and after court appear to be dissimilar. These include:

1. *Post-homicide*: to evaluate if there are 'day-to-day practicalities' that individuals require support with (e.g., paying bills, funeral arrangements), as

well as emotional support (e.g., professionals/who/where will be available if they wish so).

2. *During the legal procedures*: estimation of support needed, in order to understand how the legal process works (e.g., duration, investigations). Furthermore, it might be important to make available support to help individuals dealing with possible media intrusion and the extent of information disclosed in the media, including social media.
3. *Before the court case:* understand if individuals have specific questions about the court proceedings as well as if they have any 'special' requirements in court (e.g., a professional might be available to support them in the court).
4. *After the court case*: estimate if, and type, of psychological support individuals require (as often this is a critical period where "they start grieving").

In real life settings, assessments and support are likely to be undertaken/offered by multiple professionals (e.g., police officers, counsellors, therapist, consultants). Options to streamline this process would be useful. For example, standardised models of assessment (e.g., interviews), where core information about the individual and family could be stored and easily shared among professionals (e.g., police, NHS professionals, therapists)[34]. This could prevent individuals having to recall and share information several times. Moreover, this could avoid loss of information and miscommunication between professionals, increase efficacy and, indeed, assist in compiling evidence-based information regarding psychological, trauma and grief responses.

Finally, mapping national services available to support individuals would benefit professionals, as well the homicidally bereaved, by showing clear avenues for referral to

[34] Different levels of confidentiality would have to be taken in consideration to unsure good practice.

support. Thus, this tool could offer 'more' standardised evidence-based guidelines to be used on a national level by different professionals.

Future directions

Despite the encouraging results of this study, it was not possible to understand how previous experiences of support impacted on the overall changes. Indeed, participants reported mixed experiences of professional support received pre-EV intervention. However, it was possible to estimate that individuals reported clinical symptoms even after having reported mixed experiences of support. This might highlight the need for longer-term structured clinical interventions for some individuals.

In terms of interventions, a recent systematic review on psychological interventions for resilience enhancement in adulthood shows that there is still little consensus about resilience training, but that new problem solving strategies can be beneficial for wellbeing and adjustment following a traumatic experience (Vanhove, 2015). In fact, and given that individuals reported overall low levels of coping strategies, that could be important to increase their awareness about potential behavioural patterns (e.g., avoidance, hiding feelings) that usually impact on their overall wellbeing and help them to identify and develop new behavioural patterns which could be adopted instated. This is another avenue to consider.

Future directions on homicidal bereavement research could include:

- Multi-wave studies (avoiding short follow-up periods). It would be important to conduct follow-up measurements for a period of five plus years. This recommendation is based on the qualitative data collected with individuals who attended the EV intervention two to five years previous. In fact, they highlighted the need to try the new strategies and learn other new coping mechanisms. However, only qualitative data was collected and it

would be important to include quantitative elements to measure change in the future.

- Mixed methods approaches (quantitative and qualitative elements)
- Control groups or repeated measures comparisons to better estimate symptoms progression
- Community groups (not seeking formal support) to see how those differ from the clinical populations
- Mixed-samples with individuals grieving following a single case of homicide vs terrorist attack
- Heterogeneous samples (e.g., gender, ages and with different experiences of pre-victimisation/trauma)
- Research replication in low economic countries, where rates of homicide and violence in general tend to be greater than in Europe and United States of America. Research replication in low economic countries would provide more information about potential cultural differences in terms of impact and coping strategies.

Conclusion

This study has shown that some individuals who have been homicidally bereaved maintain severe levels of maladjustment and distress even following prior professional support, but also have moderate levels of resilience. Thus we need to consider how resilience is being measured and what constitutes resilience over time. Importantly, though, a unique four-day residential programme demonstrated reductions in psychological difficulties measured on the BSI, trends towards significant reductions in levels of PTSD and grief responses, and increased coping. For that reason, psychoeducational residential interventions with experiential elements might offer a unique context for individuals to learn more about their own emotional and

psychological responses, as well as acquire new tools to improve coping, resilience and overall wellbeing. Nonetheless, an extended follow-up period could increase understanding about resilient pathways following the EV intervention.

Personal learning

Part of the quantitative nature of this research (i.e., pre and post-intervention) occurred during the residential EV intervention. This was important, as it revealed how participants reacted to our request to fill in questionnaires. The majority felt comfortable and happy, but for some the language used was difficult to understand and there was the need for further explanations. Moreover, some participants have informally shared that they would prefer to do the interviews rather than filling in the questionnaires. This might inform future research and would be interesting to understand if clinical interviews or other data collection strategies (e.g., biochemical markers) would generate the same as self-report measures.

In terms of research, findings of this study were in line with the first qualitative study developed (chapter 3) and previous research also, as it showed that individuals reported several changes post-homicide (e.g., severe and ongoing psychological difficulties, low coping mechanisms, and the need for further support).

On a personal level, this study required rigour, precision and organisations skills, as I was collecting quantitative data at different time points (both in person and by post), and I had to insure that all the process was been well managed. Furthermore, together with my lead supervisor, I developed supervision skills, given that three students were involved in our project to help with data in-put. Finally, and due to the longitudinal nature of this research, I had to develop knowledge of core statistical elements, such as missing-ness patterns and treatment and multilevel modelling for repeated measures.

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Chapter 5:

"*The new normal*": self-perception of progress among homicidally bereaved individuals following a psychoeducational intervention

Alves-Costa, F., Hamilton-Giachritsis C., Christie, H., & Halligan, S. (accepted). "*The new normal*": self-perception of progress among homicidally bereaved individuals following a psychoeducational intervention. *BMJ OPEN* [October 2017].

Chapter Rationale

The empirical studies conducted previously as part of this thesis suggested that individuals may present ongoing psychological difficulties, as well as specific needs as the time passes by. Furthermore, understanding how they have been progressing over time and following the EV intervention was pivotal for us. Therefore, a longitudinal study was conducted with 29 individuals, in order to gain a longer-term perspective regarding their actual change and future needs.

This manuscript has been submitted to the Escaping Victimhood team for approval prior to submission to *BMJ OPEN*.

Statement of Authorship

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<tr><td colspan="10">Publication status (tick one)</td></tr>
<tr><td>Draft manuscript</td><td></td><td>Submitted</td><td></td><td>In review</td><td></td><td>Accepted</td><td>X</td><td>Published</td><td></td></tr>
<tr><td>Publications details (reference)</td><td colspan="9">Alves-Costa, F., Hamilton-Giachritsis C., Christie, H., & Halligan, S. (in submission). "The new normal": self-perception of progress among homicidally bereaved individuals following a psychoeducational intervention. BMJ OPEN.</td></tr>
<tr><td rowspan="2">Candidate's contribution to the paper (detailed, and also given as a percentage)</td><td colspan="9"></td></tr>
<tr><td colspan="9">Filipa Alves-Costa made considerable contributions to the conception of the study (50%), as well as the methodological design (70%).The experimental work, including data collection, primary data analysis and interpretation was predominantly conducted by Filipa (90%).Filipa has also executed the presentation of the data in journal format (90%), as well as presented its content at national and international academic conferences, and non-academic events.</td></tr>
<tr><td>Statement from Candidate</td><td colspan="9">This paper reports on original research I conducted during the period of my Higher Degree by Research candidature.</td></tr>
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"*The new normal*": self-perception of progress among homicidally bereaved individuals following a psychoeducational intervention

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Abstract

Objective: Research on homicidal bereavement has focused on post-loss impact and coping. Less is known about individuals' progression over time. It is already known that those adverse experiences are likely to leave individuals with an increased risk of developing severe and ongoing psychopathology, such as depression, PTSD, anxiety and grief. Therefore, this study aimed to explore how individuals perceive their change and progression post-homicide and post-psychoeducational intervention.

Design: Semi-structured qualitative interviews were conducted both as part of a prospective study and retrospectively to allow for a longer follow-up period.

Setting: Homicidally bereaved individuals who participated in a residential psychoeducational intervention offered by a national charity Escaping Victimhood.

Participants: Twenty nine individuals (mainly females-26) took part: 14 as part of a six to nine month follow-up (mean age 45.25 years, SD=7.35; range 25–70), and 15 individuals (mean age 48.50 years old, SD=8.35; range 37–73) retrospectively two to five years post-intervention.

Results: Interviews were analysed using an inductive Thematic Analysis method. Three main themes and nine subthemes were found, and applied to both groups, as follows: 1) *actual changes* perceived by the participants (increased understanding, improved coping strategies and positive self-change), 2) *barriers to recovery* (ongoing emotional fluctuation and need for support, reminders and dual grief), and finally *perceived future progression* (living by day, hope and hopelessness). The main difference between the groups was that the short-term saw support from group members as important, but this changed over time for the long-term follow-up.

Conclusion: This unique study provides insight into how homicidally bereaved individuals perceive their bereavement paths and helped to identify programme elements that appear to be effective (e.g., information about psychological responses, coping strategies).

Importantly, it has highlighted that positive changes can also be an outcome - even among participants who have continued to struggle after receiving previous support.

Kew words: Homicide, bereavement, coping, change, support, psychoeducation, intervention, Escaping Victimhood.

Article Summary

Strengths and Limitations

- This qualitative 1:1 interview study explored the progression of 29 homicidally bereaved individuals longitudinally.
- Two different recruitment processes took place (six to nine months and two to five years following a psychoeducational intervention) in order to gain a longer perspective about the individual's progression over time to inform clinical practice and policy.
- This study has considered participants who have attended a residential psychological intervention.
- A community group of participants might highlight differences between individuals with different experiences of support (or none).

The new normal": self-perception of progress among homicidally bereaved individuals following a psychoeducational intervention

Grief can be defined as an almost universal response to the loss of a loved one, albeit one that manifests in diverse ways. Approximately 45-50% of individuals tend to respond resiliently and adjust to a non-violent death in the following 12 months (Bonanno & Kaltman, 2001). Nevertheless unexpected, sudden and violent deaths (e.g., homicide, suicide) seem to be followed by a *difficult* bereavement course. In fact, the unique circunsnaces of a homicide event and aftermath, namely the sudden, unexpected and violent nature of the deaths, protracted legal processes, as well as the dual private and public nature of the grief processes (*names removed for masked review, in submission;* Malone, 2007); seems to leave individuals with an increased risk of developing severe and prolonged psychopathology, such as depression, Post-Traumatic Stress Disorder (PTSD), anxiety and grief symptoms. Family, social (e.g., Miller, 2009; Rinear, 1988) and professional circles appear to be equally impacted (e.g., Malone, 2007). However, little is known about the long-term progression of those who experience a difficult bereavement or individuals' perceptions of progress over time. Given that over a quarter of a million individuals were killed by homicide in 2015 (United Nations Office on Drugs and Crime [UNODC], 2017), it is important to understand the impact on those left behind.

Growing recognition about the psychological difficulties and severe consequences across the life span have led to the increased demand in understanding the phenomenon. Prolonged and chronic effects are often reported, such as post-traumatic stress responses (e.g., Amick-McMullan, Kilpatrick, & Resnick, 1991; Rheingold & Williams, 2015; van Denderen, de Keijser, de Huisman, & Boelen, 2016; van Denderen, de Keijser, Kleen, & Boelen, 2014), depression (e.g., McDevitt-Murphy, Neimeyer, Burke, Williams, & Lawson, 2012; Rheingold & Williams, 2015) and complicated grief (e.g., Rheingold & Williams, 2015; van Denderen et al., 2016; van Denderen et al., 2014).

However, other areas of the individuals' lives may also be impaired post-homicide, such as family and social relationships, as well as professional and economic status (e.g., Malone, 2007). In terms of personal change, research has demonstrated that homicidally bereaved individuals tend to report changed self- and world-perceptions (e.g., Malone, 2007; Miller, 2009), as well as their system of beliefs regarding overall safety (*names removed for masked review, in submission;* Englebrecht et al., 2016), and greater awareness regarding criminal activity and how ordinary people (such as themselves) can be affected by it.

Beyond the psychological effects, some research has been conducted on what coping strategies seem to be more effective. Mixed results were found regarding formal (e.g., health agencies), informal (e.g., friends, community organisations) and religious support received post-loss. Individuals reported both a strengthening of faith, but also feelings such as anger and self-questioning about God's power, a sense of non-community and/or unfairness (Asaro, 2001). Other strategies included prayer, the use of alcohol or drugs, and the avoidance of family members (Mezey, Evans, & Hobde, 2012; Sharpe & Boyas, 2011). However, gender differences in support seeking were found among parents who have lost their child through a violent death (not only homicide; Murphy, Johnson, & Weber, 2002), where mothers were more likely to seek support (e.g., formal, informal and religious) fathers were more likely to use suppression strategies to cope with their experiences.

Finally, a more recent study (Englebrecht, Mason, & Adams, 2016) has corroborated some of the evidence found previously. Individuals described positive strategies such as seeking therapeutic support, becoming involved in advocacy work, but also less positive including, distanced themselves from their grief by physically moving away, self-medicating and substance abuse and avoiding people or places. Similarly, another qualitative study similar patterns of resources post-homicide with one participant

commenting that it necessary to adapt to the "*new normal*" (*names removed for masked review, in submission*).

Despite the increasing academic interest on "abnormal" bereavement, longitudinal evidence-based research is lacking, which is vitally needed in order to estimate how individuals progress over time. Some quantitative studies were conducted to estimate psychopathology, in particular following a psychological intervention for adult homicidally bereaved individuals (e.g., Asukai, Tsuruta, & Saito, 2011; Rheingold et al., 2015; Tuck, Baliko, Schubert, & Anderson, 2012; *names removed for masked review, in submission*). However, to the best of the authors' knowledge, no longitudinal qualitative where data was collected at follow-ups studies with homicidally bereaved individuals, were conducted previously.

Thus, this study aimed to contribute to the literature by conducting a retrospective qualitative study with homicidally bereaved individuals collected both as part of prospective longitudinal study (six to nine months), but also retrospectively (two to five years post-intervention). Specifically, this qualitative research (part of a wider mixed method project) analysed the individuals' narratives, in order to address the following research questions:

1) What changes occurred over time?
2) What was their perception of the benefits of the EV residential intervention? and

2) How do individuals perceive their future selves/lives?

Method

Paradigmatic and ethical underpinnings

For this research, and in contrast with the more 'rigid' paradigms, Pragmatism informed our outcome-orientated approach. In fact, and as demonstrated before (Biesta, 2010; Johnson & Onwuegbuzie, 2006), the research team's approach sought to inform policy and practice by communicating and sharing the individuals' voices about their own

experiences post-homicide. Pragmatism, as our epistemological approach, has also reflected our belief about the potential "transferability" of knowledge to other similar circumstances. However, the research team would describe themselves as capable to keep objectively both in our reflections on research and in data collection and analysis.

The current study received ethical approval from the Psychology Ethics Committee at the University of Bath (Ref. 14-186). Participants were given full information about the research and provided written consent to participate. Furthermore, data were kept anonymised with only the first author aware of which participant number linked to which name. The other three authors only saw anonymised data. Finally, a risk plan was developed in case participants showed signs of distress or anxiety during the phone interview.

Context

Participants in this study attended a psychoeducational intervention offered by an UK charity - Escaping Victimhood (EV). EV's mission[35] is to deliver a four-day residential psychoeducational intervention following traumatic experiences, particularly homicidal bereavement. Their group intervention aims to empower individuals with 'new tools' by offering informative workshops about traumatic reactions, emotional and physiological responses likely to occur following a traumatic experience, as well as incorporating coping strategies training. Furthermore, the EV intervention offers experiential activities, such as photo, art and, therapeutic massages. Individuals who attended EV intervention are, by default, those who are struggling to adjust following their experiences of homicidal bereavement.

The research team developed a risk management plan in case individuals reported distress during the phone interview. At the end of the interview, participants were asked about how they felt and if they would need further support related the any potential

[35] More information about the EV programme can be found on their website: http://www.escapingvictimhood.com/.

emotional responses caused by our questions. Furthermore, they were given information about some possible national services they could seek help from if they needed.

Recruitment

Individuals who attended the EV intervention (six to nine months and two to five years previous) were invited to take part in this study.

Other professionals/services, such as Victims Support and Homicide Support, usually refer individuals to attend the EV intervention. Therefore, it should be noted that individuals referred have usually received significant input from other services, but continue to have significant ongoing difficulties to adjust following the homicide. In fact, and as was demonstrated in the quantitative study (chapter 4), participants reported severe psychological difficulties. For example, trauma, depression and anxiety scores reached clinical significance. The qualitative nature (chapter 3 and 5) of this research have also corroborated those findings, as individuals described themselves as changed by the homicide and reported ongoing psychological difficulties. It is important to note this research has not objectively measured the type and amount of support previously received and that this could be included in future studies.

Two different samples were recruited in order to gain a long term perspective of the individuals' trajectories post-EV intervention. First, 35 individuals who attended four consecutive groups were invited to take part in an interview six to nine months after attending the EV intervention (*short-term trajectory group - STG*). Second, individuals who took part in the EV programme two to five years previously (*long-term trajectory group - LTG*) were invited to be interviewed as well; postal invitation letters were sent to 50 individuals by EV (a randomizer software package was used to select the participants). Those individuals who agreed to take part were then put in touch with the first author.

Participants

Short-term trajectory group. In total, 14 individuals were invited to take part in the retrospective interview six to nine months following the EV intervention. Two males and

12 females with a mean age of 45.25 years old (SD=7.35; range 25 – 70) were included. The highest educational qualifications achieved by the participants were: GCSE/O-Level/Equivalent, (n=10); A-Levels/Equivalent (n=3) and, post-graduate certificates (n=1). The sample was comprised of parents (n=10), siblings (n=2), daughter (n=1), and partner of the victim (n=1). The length of time since the bereavement varied from 19 months to 18 years (mean = 3.85; SD = 1.47) at the time of interview. Five participants from this group also participated in an interview conducted immediately following the EV intervention.[36]

Long-term trajectory group. 15 female participants with a mean age of 48.50 years old (SD=8.35; range 37 – 73) agreed to take part in the interview two to five years after attending the EV intervention (mean = 3.58, SD =1.23). Participants were parents of the deceased (n=10), partners (n=2), siblings (n=2) and grandmother (n=1). The length of time since the bereavement at the time of interview varied from 2 years to 32 years (mean = 8.59 years; SD = 2.68). No information is available for the participants' levels of education.

Finally, the minority of participants (from both groups) had a past history of receiving structured interventions for psychological difficulties specifically, but the vast majority had received some kind of support post-homicide (e.g., GP, police, victims support services).

Thus, the short-term trajectory group was invited to participate in this study when they attended the EV intervention. They were given participant information forms and asked if they would like to take part in the longitudinal nature of this research. If so, Filipa Alves-Costa has contacted them directly by phone (with their permission). On the other hand, to the long-term trajectory group was given the same information, but wiling participants were invited to contact the research team to establish the first contact.

[36] Six to nine months prior the interview. The paper has been submitted to a journal for consideration.

Semi- structured interview

A semi-structured interview was developed by the authors. Thematically, this interview combined a set of flexible questions that focused on the individuals' perceptions of change post-EV intervention. In particular, participants were invited to reflect on 1) what changes had occurred over time 2) their perceptions of the impact (or not) of the EV intervention, and 3) how individuals perceived their future selves/lives.

Interview questions were developed based on a cross-literature search in a variety of areas, including: interventions, emotional responses, psychopathology, coping and resilience, homicidal bereavement experiences and victimology. The EV team (experts working in this field of knowledge for several years), as well as seven homicidally bereaved individuals provided feedback, and the interview was amended accordingly (including changes to terminology and length of the interview). Including individuals with personal experiences in the development of the interview was seen as a very helpful element of the design process. Phone interviews were conducted by the first author and recorded following the individual's consent, transcribed by an independent agency ready for coding. Duration varied from 30 to 150 minutes.

Data analysis

Interviews were analysed using an inductive *Thematic Analysis* method and Themes were identified in the data and not forced into a pre-existing coding frame (Braun & Clarke, 2006). Analyses were performed using the *QSR NVivo11* software. The qualitative data analyses followed guidelines in the literature (Braun & Clarke, 2006, 2013). In a primary phase, the first author listened to the audio recordings and read the transcripts several times before starting the coding process. Subsequently, overall codes were generated and revisited several times. In a second phase, an external coder (third author) conducted blind coding for almost 35% of the interviews (n=10), in order to ensure academic rigour and reliability. Finally, two independent coders (second and fourth authors) validated the coding system, including reviewing initial themes and subthemes,

and amendments were made (two themes were merged, as the content overlapped). Theoretical saturation – when new data did not lead to more/new information related to the research questions (Seale, 1999) – informed sample size, as suggested in the literature (e.g., Braun & Clarke, 2006).

Results

Three main themes and nine subthemes were found, as outlined below. Participants from both groups (STG and LTG) provided similar themes, therefore they were amalgamated. Figure one presents a visual summary of the super-ordinate themes and sub-themes found.

Themes

Superordinate theme one: Actual change

The vast majority of participants (n=28) felt that they had made positive changes over time, exemplified by the three sub-themes: 1) increased understanding, 2) improved coping strategies and, 3) positive self-change.

Related to the EV residential intervention, specifically, again most of the participants stated that they were very satisfied. Although initially this was a separate superordinate theme, the degree of overlap led to it be merged with theme one and the related sub-themes.

Increased understanding. The vast majority of participants (n=25) reported having gained an in-depth understanding of what emotional and psychological responses might occur following an experience of homicidal bereavement. Thus, participants reported that the EV intervention increased their overall awareness of potential emotional responses/symptoms post-homicide and described how this contributed to their better adjustment. The majority of individuals (n=20) mentioned that the EV intervention gave them "*time and space*" to "*put things in perspective*", in order to better understand their post-loss journeys, Thus, individuals' narratives demonstrated that the residential nature of the intervention was a positive aspect that allowed them to "be away" from their day-to-

day routines/contexts. In fact, this appeared to be a fundamental element that promoted self-reflection, self-care and emotional availability to better understand their responses post-loss. Therefore, participant 016 – LTG said that: "*It* [EV intervention] *reassured me I wasn't doing any wrong or doing anything to make things worse, and that it was all natural reactions*." Other participants mentioned that:

> "*It* [EV intervention] *helped me understanding how the body and the brain work. I could quite easily have seen me spiralling out of control into depression because it was just like taking over everything, and going on the course* [EV intention], *being away from it all, just cleared your mind. It made you stop and think, and helped you realise, you know, what you were going through, that you weren't going mad.* [Participant 023 – STG].

Furthermore, the vast majority of the participants (n=20) reflected upon the fact that the EV intervention gave them the opportunity to realise that other individuals have been through similar experiences of being bereaved by homicide. Listening to others stories post-loss (during social moments) contributed to an increased understanding of their own experiences, as well as seeing their emotional and physiological responses normalised, as for example said by participant 030 - LTG: "*It [EV programme] was with likeminded people and I think it did help me progress. People that actually understood what you are going through, you realise that you are not the only one*." Further, some participants (n=5) noted that their family relationships post-intervention: (Participant 023 – STG) "*I was able to, I don't know, work things out, I guess, about why my grief was different from my husband's grief and, It helped me to get the understanding that everyone reacts differently, at different times, and that was helpful*.".

On the contrary, one participant reflected on a potential *negative* side of meeting and sharing experiences: [Participant 033 – LTG] *I actually find now that I don't need them* [homicidally bereaved individuals] *because it's almost like everybody's experience is different, I don't think it helps to go over and over things with other people that have*

suffered. It's almost as if it becomes my, my experience of murder has been worse than yours and becomes a bit of a competition, and I just felt it was not, not beneficial at all.

***Improved coping strategies*.** Participants reflected on patterns of coping resources. The most frequent element described by participants (n=27) was increased understanding about their emotional responses (described above). In fact, individuals related their better adjustment to their greater understanding about psychological and physiological reactions that are likely to occur following a traumatic experience. It is important to note that some individuals do not spontaneously get better over time, showing that *it is not* just time passing. In addition, for a few individuals (n=3) the EV intervention was perceived as *too intense and academic*, and for that reason not identified as a crucial element for their overall progress over time. This was the minority of individuals though.

In general, individuals provided vague narratives when describing their coping strategies. Nevertheless, the vast majority of the participants indicated that they have been better able to cope with their experiences after the EV intervention. For example, participant 024 - STG said that "*In general, I'm coping much better, definitely much better since* [since the EV intervention]". Similarly, other participants mentioned that:

> *It's nice to reflect back on this* [ways of coping] *now actually, you know, interestingly enough. I think, when you're doing it at the time* [at the EV intervention] *you don't think you're going to be able to get through it and for it to happen, but a few years down the line that I am now, you know, I'm five years after the event and three years after attending EV, it's, it has all happened, you know. I do cope better with what has happened to us* [Participant 040 – LTG].

Additionally, it was possible to identify some information about key coping strategies that individuals seemed to have mastered following the EV intervention. Several participants (n=12; STG) reported that their communication skills improved. Thus, participants appear to have developed new strategies to better communicate/express their emotions, which improved their relationships. For example, participant 011 – STG noted

the importance of "*Communication skills. I think, if you have something on your mind or something's bothering you, you really need to communicate. You need to tell them* [relatives]". Similarly, other participant mentioned that:

> *I found it quite hard to talk as well, eh, talk about how I'm feeling and, and communicating also with my family, it was, I found it quite difficult. But having been there* [EV intervention], *I sort of like came away from it and, you know, I felt myself that I could, that I could talk about what had happened and not feel, and not feel angry and not feel upset and, you know, and sort of like be, you know, be, I felt I could communicate a little bit better, especially with my wife* [Participant 014 – STG].

Moreover, individuals (n=20) continued using some of the coping strategies learned at the EV intervention, mainly the relaxation techniques (e.g., breathing exercises, n = 15), as well art and photography (n=8). Other narratives included:

> *The photography, actually, did a lot for me, following a period of reflection. So, at the time, I just thought it was a fun, a nice thing to do, well, as did the painting, because I've still got those very close to my computer and they are looked at every day, and it made me realise that I was on a journey and there was an end. You know, you may not be able to see it, but there was an end. So, the painting, everything that you've been through, it made me realise that, not these things are done for a reason because I'm sure no one inflicts upon you for a reason, but I actually felt, okay, it's happened, and the painting and the photography started to make a lot more sense as time went on* [Participant 020 – STG].

> *I remember we were given a camera to take photographs with, and yeah I don't carry a camera around with me, but often look at things and think: Oh, I wish had a camera now. And it made me start looking at the nature and look up again. I was very down, constantly just looking at the ground* [Participant 043 – LTG].

In addition, several individuals from the STG (n=8) indicated that they gained informal support by keeping in touch with some of the EV participants, with that being identified as a helpful coping resource. Notably, keeping in contact was only referred to by two participants in the LTG, suggesting that it is a useful strategy in the shorter term, but has less value as time goes by. As the following quote illustrates:

> *It's nice to be able to just get a message or a picture or a text message because you know that that other person is thinking about you and I'm thinking about them, and although you don't meet them and you don't see them because they live quite a way away, you know that that person's thinking about you and you know that they're going through the same as what you're going through. It's hard to explain because we don't really talk about it* [homicide], *but they are there for you* [Participant 024 – STG].

From the participant's narrative it is possible to understand that the EV intervention have helped her to adjust to a new reality where her loved one is no longer there, but where it is possible to live and where positive feelings were transformed in a more positive mind-set.

Positive self-change. More than half of the participants (n=23) referred to positive self-changes that impacted on their overall adjustment since their loss. The narratives of the participants reflected some 'new behaviours/attitudes' that had developed. Again, there was a strong sense that the EV intervention played an important role for the majority of them (n=20). In fact, participants reported some examples of personal change that occurred over time in terms of emotional adaptation, psychological functioning where individuals identify their 'new normal' in a changed reality:

> *Now I know that I'm allowed to have good days, I'm allowed to laugh, I'm allowed to smile, I'm allowed to have a normal life, and therefore, since the programme, of course I still think about dad, of course I do, yeah, I'm allowed to*

be normal. I can go back to being me without feeling guilty [Participant 12 – STG].

Similarly, another participant noted that:

It [EV intervention] *just really went to help bring out the person I really am, out of this terrible abyss that you feel you're* in*. It did help me to realise how strong I am and helped me along the way I think and see myself* [Participant 40 – LGT].

Positive self-growth. Despite the positive self-changes reported, only a few (n=4) individuals from the LTG (none from the STG) reported self-growth (i.e., development as an individual over and above learning positive coping styles and where they were before). For example, participant 033 – LTG said that: "*Everything is taken for granted. They* [people, in general] *should not take it for granted, because it's not. It* [event] *made realise that we just cannot take life for granted, love and care as much as you can*." Other participants mentioned that:

And do you know, looking back, I think I'm a better person since [event] *I'm stronger, I understand more, I value life, I value every day I live. When you lose a child, everything became so precious, every second that you spend with people that you care about, your loved ones, people close to you, treasure everything that they say and do* [Participant 032 – LTG].

A minority of individuals (n=4) have even demonstrated that the event made them realise how crucial life in general and relationships in particular are and how one should invest in those domains. Furthermore, some described how helping others with similar experiences has become their new purpose in life.

Desire to help others. Finally, for some individuals (n=4), the positive self-change was visible as they wanted to help others going through similar experiences, as it is illustrated in the following narratives:

I did my masters, my dissertation on support needs as well, for homicide. I did a literature review. My dissertation was something that I worked really hard on and

felt like, like you, like, you know, you can make a difference, hopefully, one day [Participant 020 – STG].

I would never have been able to come through this as I have done without the help that I'd had in this country, from the EV and others charities, like Victim Support. So, what I want to do now is peer support course, even though I'm going out there [leaving the UK], *I can help people in an international level* [Participant 015 – STG].

Role of the Escaping Victimhood programme

In summary, as noted above, participants were generally very satisfied with the EV-intervention and felt it had contributed to a better adjustment post-homicide. In fact, participants identified key EV elements that were pivotal for their overall wellbeing post-intervention, including the group psychoeducational nature of the EV intervention, the more personalised one-to-one sessions with the facilitators, as well the experiential components of the programme (i.e., therapeutic massages, art and photography). Finally, the residential, warm and nurturing environment provided by EV was highly praised by the participants. Almost all of the interviewees (n=28) stated that they would recommend the EV programme to other individuals who had experienced similar trauma.

Superordinate theme two: Barriers to recovery

The second super-ordinate theme reflects elements participants identified as holding them back. Sub-themes emerged, as follows: 1) ongoing emotional fluctuation and need for support, 2) reminders and, 3) dual grief.

Ongoing emotional fluctuation and need for support. Almost all of the participants (n=26) described having felt ongoing emotional fluctuations since the event. Despite perceptions of improved wellbeing and mental health over time, the vast majority described intense and ongoing emotional responses. Consistent with that, individuals identified that ongoing support would be helpful. Further, despite acknowledging a better adjustment over time, and also following the EV programme, the majority of participants

highlighted the fact that such life changing experiences should require singular attention from the authority bodies. In fact, almost all of the individuals (n=20) described that it would be helpful getting structured ongoing support where their ongoing needs would be followed-up over time, as said by Participant 022 – STG: "*It would be lovely if there was somewhere like where you could go maybe every six months or whatever*." Furthermore, participant 033 – LTG shared that "*I do really get bad days, and sometimes I feel like it would be just nice to talk to somebody. It would be nice that they would be there if needed*." Similarly, other participants stated that:

> *I'm okay, as you can expect, some good days, some bad days, some very bad days, and then, you know, it goes in circles. It just goes round and round, and trying to adjust to this, you know, this life without X* [deceased daughter] *is so very difficult. And having someone to talk to would help me, I think* [Participant 018 – STG].

> *Sometimes I do get really bad days, and sometimes I feel like it would be just nice to talk to somebody, but it's almost like I can see that, that's something that can't be fulfilled because it's almost like I want it now. I don't want to wait for an appointment! I just want to talk to somebody now. It sounds a bit like Samaritans that you can ring up if you need to. It would be good* [Participant 033 – STG].

Reminders. Several participants (n=10) identified reminders that were likely to impact on their overall maladjustment, such as special dates and occasions (e.g., birthdays, anniversaries, Christmas). Furthermore, social media platforms (e.g., *Facebook, Twitter*) were also described as increasing their anxiety and emotional pain, as deactivating social media accounts of the deceased could be a prolonged processes, as described:

> *Then you have special occasions where you know she* [victim] *is not going to be there, and this is just impossible to describe.*"; *"It is very difficult. It took us months and months until her account was completely deactivated. It was painful, very much painful* [Participant 017 – STG].

***Dual grief*.** Three participants have mentioned that their dual grief was a factor that was holding them back, due to their close relationship with both victim and offender and how that had a greater negative impact in their lives. Further, participants highlighted some particular issues that are likely to occur, namely, the emotional ambiguity felt regarding their relatives who committed the homicide. Moreover, participants reported family difficulties where changed relationships occurred or all contact ceased. Finally, individuals reflected on a perceived social stigma, as well as how the criminal justice system seems not to address the particularities of such experience, as it is illustrated by the following narratives:

> *It* [homicide] *destroyed our family. My father is in prison, my son is dead*." and Participant 033 – LTG also said that: "*I am the perpetrator's parent and also the victim's grandmother and it all just becomes a bit too much entwined for me to figure it out*. [Participant 07 – STG].

> *I am the dad of the victim and the dad of the offender*. *And so, I have no faith in the legal system, justice system, and in the prison. I can't get to the prison easily. It's nearly a 400-mile journey*. *What I'm doing at the moment is hanging on to try and be there for my son when he* [his son] *comes out* [of the prison], *because he's going to have an awful lot to cope with and he's going to need my help* [Participant 017 – STG].

Superordinate Theme Three: Perceived future progression

This super-ordinate theme relates to the participants' perceptions about their future. Sub-themes emerged, as follow: 1) Living day by day, 2) Hope, and 3) Hopelessness.

***Living day by day*.** Despite making many positive changes, overall narratives of the majority of the participants (n=22) demonstrated that they continued to live day by day without forward planning. In fact, participant 018 – STG said that: "*I don't look far ahead anymore*. *It's a strange thing*. *I tend to live at the moment very much day-to-day and get along with, you know, go and get along with what we're doing*." Similarly, other

participants mentioned that "*I just take one, literally, one day at a time"* [Participant 025 – STG] and "*I just cannot think about the future, I go by day*" [Participant 041 – LTG].

Hope: Several participants (n=15) were optimistic about their future. Their narratives acknowledged the chance of going through difficulties in the future, as they were living and adjusting to a changed reality. However, it also identified a perceived will to "*live again*" in their "*new reality*", as it is illustrated by the following narratives:

> *The future's good. It's not, it's not going to be easy. I mean, the past three years haven't been easy, but, you know, every day, every week, every month, it's getting better. You can never forget anything like this* [homicide], *but you have to deal with what's in front of you, you know, and I think, you know, like I say, with the support of my family and friends, you know, it can, you know, it can only get better* [Participant 014 – STG].
>
> *It's taken most of my life* – you know*, I'm nearly 50 now, it took so many years away to get help. But, there's a bit of brightness for the future than what I did have before* [pre-EV intervention]. *So, even though I've lost about 23 years, at least maybe I can scrape some back. If I hadn't have come to your course* [EV intervention], *I probably would never be in that mind-set* [Participant 022 – STG].
>
> *I didn't work for a while, because I had my grandchildren living with me, until they went to live with their mother. I had my own business, but I gave up* [following the homicide] *and actually, we had a refugee centre near where I live and they deal with domestic abuse and run three charities shops and I have been working with them for a while now, and they offered me a position as supervisor in one of the shops, just this week. So it feels a bit brighter* [Participant 032 – LTG].

***Hopelessness*.** Five participants were hopeless about their future demonstrating greater distress and even two of them reported that they wish they had also died. For example, as said by participant 043 – LTG: "*I have survived, but sometimes I wish I*

hadn't. I don't mean I want to be [recognised as] *a victim, but wish I had died, to be honest with you. I really wish I had died that day because, do you know what, it would have been easier to die than to suffer like this*." Similarly other participants mentioned that:

> *I'm already depressive. I already feel that my life isn't worth living. What I'm doing at the moment is hanging on to try and be there for my son when he* [his son] *comes out* [of the prison], *because he's going to have an awful lot to cope with and he's going to need my help* [Participant 017 – *STG*].
>
> *I'm going to be 75 this year, so I don't expect to be a long one, and I'd just like everything to be in order before I finish, and I'd like to think the charity keeps going* [referring to a charity that she has created to support individuals post homicide; Participant 023 – STG].

The participants' narratives explored in this study demonstrate that adjustment it is a possible outcome following an experience of homicidal bereavement. In fact, the majority of our participants reported positive actual changes over time and following the EV intervention. Indeed, new coping strategies were reported, as well as their own understanding about the experience itself of being bereaved by homicide. Nevertheless, barriers to recovery were still identified, such as the ongoing emotional distress and the need for further support and this is likely to inform practice in the future, as it will be discussed in the next section of this paper.

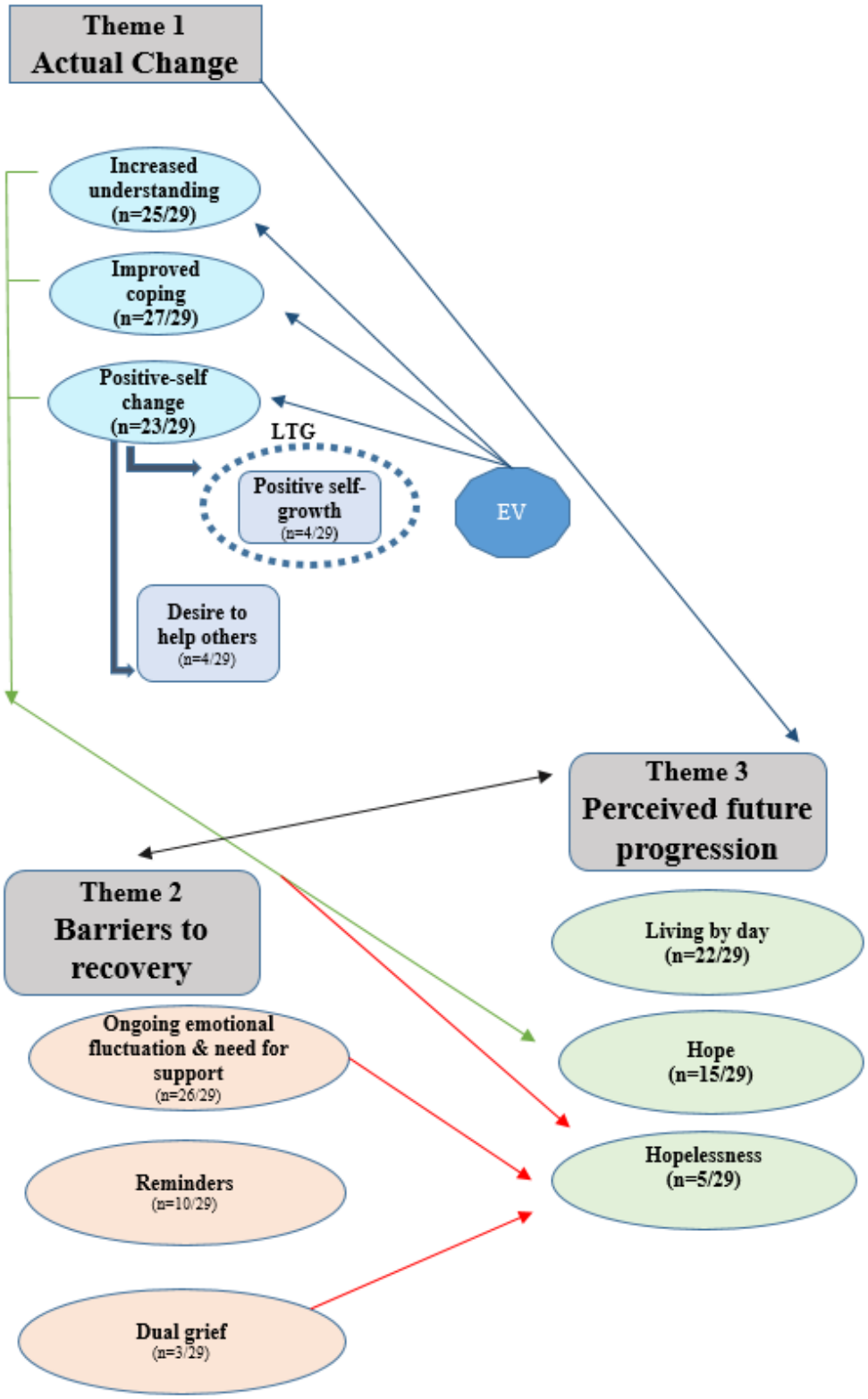

Figure 1. Thematic map with themes and subthemes.

Discussion

This study aimed to explore how individuals perceive their progression post-homicide following a residential psychoeducational intervention. As might be expected, a range of responses were found with some individuals reporting *more* change than others. Indeed, some described post-bereavement self-growth, while others stated that they wished they had also died. Thematic analyses was used to analyse the data and three main superordinate themes were found, as follows: 1) *actual changes* perceived by the participants (increased understanding, improved coping strategies and positive self-change), 2) *barriers to recovery* (ongoing emotional fluctuation and need for support, reminders and dual grief), and finally *perceived future progression* (living day by day, hope and hopelessness).

Firstly, the main superordinate theme (*actual change*) and subthemes, illustrate patterns of change post-homicide and following the EV intervention. Participants developing understanding of the diverse psychological difficulties that might occur post-loss, and progress, seemed to be pivotal. This affected not only their ability to cope but also often was reported to have impacted on their relationships with family members, enabling better understanding of others' experience different responses, as well as making sense of their experience (e.g., Armour, 2002, 2003; Currier, Holland, & Neimeyer, 2007). This is consistent with previous research where *not knowing* about grief processes was considered unhelpful (Armour, 2002; Paterson, Chaston, & Malone, 2006).

Regarding other coping strategies, increased informal support by keeping in touch with some of the individuals that they met at the EV intervention worked predominantly for the STG. This was less so for the LTG participants – for this group, as time went by, contact with the other participants lost its value. Thus, it may be that the initial awareness of knowing you are not alone and normalisation of responses, is important at the onset but loses its usefulness over time. To the best of the author's knowledge, previous studies have

not explored this, hence further studies would be useful. Continuing with the relaxation techniques (e.g., breathing exercises), art and photography also appeared to be very positively received by the participants. Use of these alternative, experiential techniques is not well-addressed in the HB literature, but potentially is an area worthy of further study. In fact, only one study have mentioned art as a coping strategy used by the individuals post-homicide. Other research among victims of crime suggests that those coping strategies might effective post-trauma (Blatner & Blatner, 1997), post-sexual abuse (Emerson, 1992), as well as following domestic violence (Emerson, Deborah, & Shelton, 2001).

Individuals also reported new behaviours/attitudes (e.g., social, professional interactions, helping others). This is consistent with a recent qualitative study (Englebrecht et al., 2016), which found that individuals found seeking therapeutic support and becoming involved in advocacy work were both perceived as positive coping mechanisms. Hence, it may be that finding new meanings or focusing on others works well for some people. Notably, a few (n=4/15) LTG individuals even reported personal self-growth post-homicide. In a review of the literature, Linley and Joseph (2004) reported that despite the adverse outcomes, positive changes can also be an outcome following traumatic events (e.g., chronic illness, rape and sexual assault, military combat, maritime disasters, plane crashes, bereavement). Perhaps unsurprisingly, the majority of reviewed literature suggests that type of traumatic event does seem to impact growth, as well as other elements, such as individual, social and cultural factors (e.g., Casey, 2011). Indeed, Casey's (2011) research has highlighted that individuals bereaved by homicide are likely to suffer from long lasting psychological difficulties and that should be considered in terms of support offered in the UK. Our study has also identified that individuals suffer from severe and ongoing emotional distress and that a longer-term and integrative support is needed.

Nevertheless, non-adaptive strategies were also reported, such as physically moving away, self-medicating and substance abuse and, avoiding people or places corroborating another recent study (e.g., Boelen et al., 2016; Murphy et al., 2002).

Secondly, and despite the positive changes reported, superordinate theme two summarises what the participants perceived as *barriers to recovery*. Thus, ongoing emotional fluctuation (e.g., emotional pain, depression, exhaustion) was repeatedly highlighted. This is probably to be expected and perhaps could an element of any programme, emphasising the normality of this. Their narratives suggested that homicidally bereaved individuals have different needs over time, due to the unpredictability of their emotional responses. Thus, individuals would possibly benefit from re-assessments as the time goes by. In fact, and given that individuals have reported different needs over time (e.g., aftermath, post-court hearings), services could offer to reassess their needs at different times, to ensure the families' individual psychological and practical needs continue to be met.

One area that professionals can assist with, however, is the impact of dealing with social media (including reminders about special occasions), with very practical advice about how to work with organisations to close down victims' accounts, for instance.

Another key area to consider are those participants who have dual grief (i.e., close relationship with the offender and victim). This group, albeit very small, appeared to have greater difficulties that were less responsive to the intervention. In fact, the three individuals who described hopelessness about future were all dual victims. Again, this is perhaps not surprising but does highlight that this group it is unique and may require specific elements of support, related to this duality. Some studies have found that intra-familial homicides increase the psychopathology and are more complex to make sense/process (Harris-Hendriks, Harris-Hendriks, & Kaplan, 1993; Rynearson, 1984). On the contrary, van Denderen et al. (2016) found perpetrator-related correlations with PTSD and CG responses. Further longitudinal research is needed to better understand if relationship with the offender impacts on individuals' psychopathology differently as the time passes by.

Thirdly, superordinate theme three reflects the individuals' *perceptions about their future*. It was interesting to see that most retained the focus of living day by day without further

planning, yet half spontaneously reported hope towards their future after the programme. Conversely, five felt hopeless and two still stated that they wished they had died. Future research should investigate this better, specifically by looking at pre-loss patterns and personality traits, for instance. Although this was not within the scope of the current research, it would be important to objectively measure personality traits using validated psychometric questionnaires (e.g., the five factor personality traits), as well as consider to explore (more) past adverse experiences. Hopefully, this could inform researchers about potential individual differences in coping strategies and better inform practice.

In fact, research conducted with victims of crime suggests that resilience is highly correlated with flexible personality types (Bonanno & Mancini, 2008), adaptive coping resources (e.g., pragmatic coping; Bonanno, Galea Bucciarelli, & Vlahov, 2006), successful past experiences of supportive and healthy relationships, as well 24as good community resources (Luthar, Cicchetti, & Becker, 2000; Luthar, 2006). Prior experience of extreme distress (PTSD) seems to predict resilience in future difficult circumstances. Therefore, and as noted by Bonanno and Mancini (2008), the co-occurrence of these factors will impact on the different resiliency paths of each individual and this should be included in future research.

Strengths and limitations

This study has extended previous research on homicidal bereavement, particularly in terms of progression over time. To the best of the authors' knowledge, the research conducted up to date has mainly estimated psychopathology at different time-points, especially following psychological intervention settings. In fact, only a few quantitative longitudinal studies have estimated base-line levels of psychopathology (i.e., at the beginning of psychological interventions), as well as progression usually six to 12 months after the intervention (Asukai et al., 2011; Rheingold et al., 2015; Tucket al., 2012; *names removed for masked review, in submission*).

Overall, these previous quantitative studies demonstrated that psychological interventions are likely to contribute to the decrease of psychopathology post-intervention and that the positive results are maintained at follow-ups assessments (op cit). However, these studies did not consider participant perceptions of what was useful. Thus, the current study extends the previous research by highlighting what elements seemed to have contributed to the individual's change over time, and therefore should be considered in interventions.

Despite the strengths, results of this study should be interpreted in the context of some limitations. First, this study only included participants that took part in the EV intervention and were predominantly females and parents. Therefore, it would have benefited from the inclusion of a more diverse group of individuals, including those that had not attended an EV programme, as well as individuals not seeking psychological support, in order to estimate potential different bereavement paths. However, attempts to find community samples were unsuccessful, hence should be an area for future research.

Clinical implications and future research

Based on the information received from participants, interventions work well when they are group based provide psychoeducation but also experiential activities and ongoing support. The residential nature was highlighted as very beneficial, not least because it allows participants space to be away from the dynamics within their family home and concentrate on their own style of grief (e.g., how personality traits might impact on individual differences), whilst developing understanding about others' grief responses. However, one area that could be further developed is the forward planning for when participants return home to the 'cold reality'. This can include behavioural approaches, such as activity planning and goal setting, but perhaps also might include an exercise about how to match one's own grief reaction with those around them.

Generally it can be quite difficult to identify sources of support in different geographical areas. Hence, clearly mapping services would be of benefit by showing clear

paths for referral to support individuals' over time. The National Homicide Services could perhaps cooperate with local charities and services in order to insure that an integrative support is been delivered to the families not only on the aftermath, but also as the time passes by.

Future research would benefit from the inclusion of pre-homicide variables, such as personal characteristics, social interactions and worldviews, as they are likely to impact on how individuals respond and progress over time following an adverse experience. Moreover, further longitudinal studies would give additional information about long-term progress. Finally, replication in low economic countries, where rates of homicide and overall violence tend to be greater than in Europe and United States of America. (e.g., Brazil, South Africa) are necessary, so that decisions about interventions for homicidally bereaved individuals are not based on almost exclusively European and American data. Furthermore, such research might provide information about the impact of single or multi-victimisation exposure.

Indeed, for trauma research for instance, some hold the view that PTSD research is not global enough, that it really only focuses on Western countries – and mainly military populations within Western countries for that matter. It is known that individuals from low and middle-income countries (LMICs) may be at higher risk of exposure to continuous trauma (e.g., interpersonal violence, homicide) due to the unsafe environment in which they and their families live in. Furthermore, they have extremely limited access to formal psychological and welfare services, which has issues routed in the cost of these services, but also a lot of cultural barriers as well. Therefore, would be important to understand how individuals describe their experience following a homicidal bereavement, as well as their experiences of support (both formal and informal). This, would contribute to an in-depth understanding about traumatic experiences of bereavement.

Conclusion

This study adopted a qualitative longitudinal approach and highlighted new avenues to support homicidally bereaved individuals and help them to adjust to a "*new reality*". Despite ongoing emotional fluctuation, the current study demonstrated that positive-self change (even, occasionally, self-growth) is possible amongst this unique group of individuals with long-term difficulties even following prior intervention. In contrast, some continued to struggle to make any positive change. Hence, more work is required to consider how best to continue the positive change for those who have it but to start the process of positive change for those still struggling.

Specific elements of the interventions appear to play an important role. For that reason, psychoeducational residential interventions with experiential elements might offer a unique context for individuals to better understand psychological responses, as well as acquire *new tools* to improve coping, positive-change, resilience and overall wellbeing. As noted by one participant, the programme had helped them to "*to look up again*".

Personal learning

The current and final study was crucial to consolidate and extend the findings gathered in our previous studies, as it followed-up the individuals qualitatively and gave them the chance to share their narratives in terms of change, barriers and future support. Indeed, individuals reported actual changes since they took part in the EV intervention and reflected on what barriers are still present in the lives. When this study was completed, the research team had a sense of connectives between the studies where the voice of our participants was very present. Thus, this have definitely proved that adopting mixed methods and longitudinal designs are crucial when studying complex social phenomena, as are homicidal bereavement experiences.

On a personal level, the format of the interviews required adjustment, as it was the first time I was conducting phone interviews and I feared that individuals would not share their stories or that I would not be able to support them in case of extreme distress. Nevertheless, this did not occurred, instead all the participants were very happy and comfortable with the phone interviews, (even individuals who took attended EV two to five years ago and I have never met in person). Furthermore, it was a quicker and low cost strategy to conduct the interviews, given that the participants were based in a variety of areas in the UK. Thus, this showed me that phone interviews can be effective, as can be seen by the fact that it is now largely used either by national and international research teams.

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General Discussion

Aims of the thesis

The overall aim of this research was to explore how individuals perceive their post-homicide reality, as well as progress over time following an intervention by Escaping Victimhood. The empirical research produced in this thesis corroborates and extends understanding about homicidal bereavement by focusing on five main aspects:

1. Providing a summary of the main findings across the homicidally bereavement literature, including impacts and coping response, and comparing it to non-violent loss (Chapter 1).
2. Systematising evidence about what psychological interventions are available to help homicidally bereaved individuals and their effectiveness (Chapter 2).
3. Considering how individuals 'see' and 'feel' the post-homicide experience in terms of change, perceived support and coping responses (Chapter 3).
4. Estimating levels of overall psychological difficulties, PTSD and CG, as well as including coping and resilience patterns over time and post EV intervention, as well as testing potential patterns between socio-demographic, victim and perpetrator relationship and psychological difficulties (Chapter 4).
5. Monitoring individuals' progress and exploring their perceptions of change and future self-views, as well as barriers to recovery (Chapter 5).
6. Exploring individuals' perceptions about the impact of the EV intervention on their adjustment over time (Chapters 3 and 4).

Summary of findings

Chapter 1. *From theoretical frameworks to the particularities of homicidal bereavement experiences: a narrative review*

The narrative literature review presented an overview of key bereavement models and provided a theoretical framework from the literature. It summarised current knowledge and understanding of homicidal bereavement, including definitions, prevalence, impacts post-loss and potential moderator effects. It also provided a reflection about violent and non-violent losses and reflected on limitations. There is little UK-based research on homicidal bereavement experiences and therefore this thesis sought to contribute to the lack of evidence developed to date. Thus the overall aim of this research was to explore how individuals perceive their post-homicide reality, as well as progress over time following an intervention by Escaping Victimhood. The empirical research produced in this thesis corroborates and extends understanding about homicidal bereavement experiences.

Chapter 2. *A systematic review of psychological interventions for homicidally bereaved individuals*

The systematic review identified a lack of specifically adapted interventions and available evaluations for children, adolescents and adults bereaved by homicide. The small number of studies included in the review demonstrates that limited evidence-based research has been conducted. Nevertheless, this review demonstrated that the psychological interventions included were effective at decreasing psychopathology in terms of PTSD, CG and depression.

Overall, the group interventions studied included psychoeducational elements, coping skills, relaxation training and emotional support, as well as exposure and death imagery. Therefore, these approaches should be considered (where possible) in clinical practice, policy and research settings. Finally, a closer relationship with the victim and

having been homicidally bereaved (compared with other forms of violent bereavement) were linked with greater psychological difficulties even post-intervention. Time since loss did not impact on the outcomes. It is important to note that comparisons between the included studies was difficult due to the unequal samples sizes, different interventions and study designs. Thus, future research should focus on intervention efficacy, in order to clearly understand what elements of an intervention contribute the most to change.

Chapter 3. *"Everything changes": Listening to homicidally bereaved individuals' practice and intervention needs*

The qualitative study conducted with 21 homicidally bereaved individuals (during the EV intervention) highlighted how individuals perceive their changed reality post-homicide. Indeed, this study describes how they 'see' their experience as *unique* when compared to other general adverse experiences and to non-violent loss, in particular. As identified in a few other studies, the nature of the homicide itself (i.e., often sudden, unexpected, deliberate and violent) seem to increase individuals' suffering in the aftermath. Moreover, the criminal investigations, uncertainties (such as missing body), legal processes and the publicity through the media were seen as dissimilar to other bereavement and difficult to deal with.

Perhaps unsurprisingly, individuals described themselves as changed by the homicide, where intense psychological responses, changed professional/financial and worldviews were reported. Finally, their perceptions of mixed experiences of support (not always positive) led to suggestions for future improvements (clinical practice and social awareness). Thus, the outlined variables are likely to inform clinical practice (e.g., case formulation and intervention design), as well as policy (e.g., the need for social awareness and professional training).

Chapter 4. *Longitudinal outcomes following homicidal bereavement and psychoeducational intervention*

The longitudinal (i.e., four time-points) study conducted with homicidally bereaved individuals attending the EV psychoeducational intervention, reported high levels of psychopathology, PTSD and CG at baseline measurements (before EV intervention). This reminds us that the participants of EV interventions are those individuals who continue to struggle significantly even after other forms of support, such that their difficulties appear quite entrenched.

Despite that, post-intervention assessments (post-intervention, 4-6 weeks and 6-9 months) revealed a statistically significant decrease of psychological difficulties over time, albeit not to below clinical significance. This latter merely highlights that severe and ongoing psychological responses are likely to occur among this population, but it is notable that significant reductions were found after four days. However, homicidally bereaved individuals might require monitoring and support for longer periods, as will be discussed.

Despite overall poor coping patterns, individuals demonstrated increased cognitive and emotional skills from follow-up I to II. This might suggest the need for a *more* structured approach to developing coping in the EV intervention. Furthermore, it also highlights that to acquire new coping strategies might require *time*.

Finally, overall, individuals reported medium to high resilience patterns at all time-points (follow-up scores were slightly higher than baseline scores), showing that maladaptation is only one possible outcomes following many forms of trauma. Furthermore, this might be related to the fact that those individuals have had other opportunities of support previously that have contributed for their satisfactory levels of resilience. Nevertheless, future research needs to be conducted.

In summary, results showed that psychoeducational residential interventions with experiential elements might offer a unique context for those individuals who are struggling the most, to learn more about their own emotional and psychological responses, as well as

acquire new tools to improve coping, resilience and overall wellbeing. In addition, it also highlighted the need to further understand whether solid blocks of intensive interventions differ or not from the more conventional settings of weekly sessions extended in longer period of time. Indeed, that would be important to conduct clinical trials where the variable "intervention settings" could be measured in order to understand if individuals benefit more from intensive blocks of intervention or longer-term weekly sessions of intervention.

Chapter 5. *"The new normal": self-perception of progress among homicidally bereaved individuals following a psychoeducational intervention*

Finally, the longitudinal qualitative study monitored 29 homicidally bereaved individuals post-intervention within two different groups of participants (14 were interviewed 6-9 months post-EV intervention and 15 were interviewed 2-5 years after they took part in the programme).

Individuals reported change mainly in terms of increased understanding, coping and positive self-change, reporting that they felt the EV intervention played an important role. However, despite the overall increased adjustment over time and following the EV intervention, individuals identified ongoing psychological difficulties and need for (further) support. Reminders (e.g., special dates, anniversaries) were described as difficult to manage.

Another barrier to recovery was perceived by a few individuals who were close relatives both to the victim and to the offender (dual-victims) and, perhaps unsurprisingly, reported greater distress and poorer adjustment.

It was interesting to see that most participants retained the focus of living day by day without further planning, yet half spontaneously reported hope towards their future after the programme. Importantly, this study highlighted the need for further understanding of pre-loss patterns and personality traits, for instance. Overall findings demonstrated that despite perceived ongoing psychological difficulties, individuals reported change and

adjustment to their 'new reality' and that the strategies learned previously at the EV programme empowered them.

Integration of findings

Studying death and dying is not a recent area of interest, but it has tended to focus more on non-violent loss. Homicidal bereavement (violent-loss) is possibly one of the most adverse and horrific experiences that one can face over time. The media 'share and sell' high profile cases, with films, television and stories telling and re-telling 'the story' of those left behind. Nevertheless, and despite the growing interest among academic communities, there is still limited evidence-based research looking at this phenomenon.

The research detailed in previous chapters has demonstrated that this group of individuals are very likely to develop severe psychological difficulties (e.g., PTSD, depression and CG) and health impairments (e.g., sleep deprivation, eating issues). Perhaps unsurprisingly, often professional, financial and social issues are also reported, as well as difficulties coping. Despite the enormous value of the research conducted before, it had been unclear how individuals progress over time, their needs, and what psychological interventions appear to be effective to help them.

Thus, the studies presented in this thesis sought to increase understanding about the post-homicide reality, as well as highlight 'new avenues' for practice and policy. The following sections offer a general discussion of the main findings by embedding the diverse empirical data elements (systematic review, qualitative and quantitative), in order to address the research aims established by considering three main areas under study, mainly: 1. Post-homicide reality; 2. Psychological difficulties & coping and resilience patterns; and 3. Interventions and support needs. Finally, limitations, recommendations for EV, clinical practice and policy are discussed, as well as future directions for research.

1. Post-homicide reality

"*You cannot compare, there's nothing like this!*"

(Participant 017)

Participants described their post-homicidally reality as "*unique*" when comparing it to other potentially adverse experiences, as well as non-violent deaths, with this potentially informing researchers and professionals about how those individuals 'see' and 'feel' it. As described in Chapter 3, homicides are often sudden and unexpected where another person (usually) deliberately and using violence kills another person. Perhaps unsurprisingly, death-related stimulus (e.g., intrusive thoughts or recurrent images related with the crime scene, pictures of the scene and/or body) were linked with an increased risk of PTSD and CG symptoms in previous research (Boelen et al., 2016; Prigerson et al., 1995; Rheingold et al., 2015; Rheingold et al., 2012).

Another element that was described as "*unique"* was the protracted criminal investigations legal proceedings. Indeed, participants' narratives demonstrate how those usually long and uncertain processes are additional sources of distress for them and seen as inhibiting their grief responses. In fact, individuals' referred to the dissimilar aims of individuals versus the State. This starts with the lack of information about how both those processes work and progress over time. Indeed, the majority of individuals had not had previous experiences with such systems, and therefore this was frequently linked with maladjustment and increased distress, as was noted previously (e.g., Armour, 2002; Asaro, 2001; Malone, 2007a, 2007b). Furthermore, some of the participants described confusion/uncertainty about their '*victims' status*' post-homicide. Indeed, it was not always clear for them to understand their eligibility to get support. Finally, and very strongly described, individuals consider that when the legal processes end, they "*start grieving*", with this highlighting the potential need for longer periods of monitoring, as was noted in few previous studies.

Finally, the publicity of the individual's grief by the media was considered intrusive, judgemental and often disrespectful towards their families and loved ones' memories. This dual private and public nature of their grief processes was seen as especially likely to occur when violet-deaths happen, as homicides are seen as profitable stories. Nevertheless, this is very likely to contribute to the individual's distress, due to the constant uncontrollable stories shared by the media sources and potential family exposure, as well as contributing to a perceived social stigma and labelling (e.g., being easily identified as relative of X killed person). This was also described in a few studies conducted before (e.g., Asaro, 2001; Amour, 2002; Dawson & Riches, 1998).

The findings of this study shed light on the experiences of these individuals bereaved by homicide and could help inform healthcare and welfare practice. Indeed, individuals' narratives regarding their post-homicide reality and their patterns of adjustment over time are a significant contribution of this research.

As described above, for these individuals the homicide is 'only' the beginning of a their journey where their perceptions and experiences of support and understanding will shape their adjustment post-loss. This research did not seek to directly understand how meaning-making can impact on how individuals respond and adjust. Nevertheless, it important to reflect on how individuals perceive themselves post-loss and this may actually link (to a certain extent) with their ability to find the meaning for their experience.

Linking back with the literature explored in the literature review of this thesis, models of meaning making offer an idiosyncratic process to understand grief responses, where individuals are invited to find *the meaning* of their loss experiences. This process involves: redefining the self and how to engage with the world. Previous research has demonstrated that the meaning making model is seen as an adaptive strategy and suggests that a non-coherent/disorganised narrative of the bereavement experience might impact on how individuals respond to the loss. Failing to find meaning increases the risk of

psychopathology, as it seems to involve a constant rumination around the event (Neimeyer, 1997; Nadeau, 1988).

Regarding traumatic bereavement (not exclusively by homicide) a few studies have also highlighted the potential inability to find the meaning of a violent experience of bereavement, with this differing compared to non-violent losses. Indeed, the failure of meaning-making for violent losses relate to the change of one's fundamental beliefs and assumptions about self and others (Currier et al., 2006; Janoff-Bulman, 1992; Rynearson, 1988) leading to the development of anger, unfaithfulness and/or trust issues.

Considering previous literature and the findings of this research, homicidally bereaved individuals are changed (in many ways) by the homicide and describe a somewhat loss of identity. Their ongoing, often severe emotional and psychological difficulties together with the challenging loss-related demands (e.g., funeral arrangements, police and legal proceedings, media intrusion) greatly impact on their ability to understand, process and find the meaning for their experience. For that reason, it is crucial for individuals to 'find' their new identities post-homicide.

Quite often our participants reported that to 'go back to their normal' and attempting to 'make things' as they were before (pre-homicide) were described as ineffective strategies. This has potentially impacted on their overall maladjustment and distress, as pragmatically this is something that cannot occur, due to the changed reality. On the contrary, the ability to 'find' their new-selves has improved their adjustment and this is likely to be linked with their improved ability to find the meaning for their experience. Indeed, when individuals realised that their pre and post-homicide realities are not likely to be similar, individuals appeared to respond to their experiences with a *more* positive mind-set. The 'new normal' reality is a significant finding of this research which highlights the possibility to explore with individuals their perceptions and new meanings.

Regarding intervention/clinical settings and considering those findings, it seems important for professionals to explore with their clients the meaning of their old and new

selves/identities (i.e., pre and post-homicide), which is likely to help them to decrease levels of rumination about living a life where there love-ones are no longer there. Furthermore, it is also crucial for individuals to re-find themselves in a new reality, where family, social systems and worldviews are also new domains.

This study supported previous somewhat limited research regarding post-homicide experiences and needs, highlighting new pathways to understand the experiences of those bereaved by homicide. Avenues of clinical support were discussed and future practice could consider the individual's voice in order to help them/promote their adjustment to a possible "new normal" in a changed reality.

2. Psychological difficulties, coping & resilience patterns over time and post-EV

"How can I explain? Everything changes, really"

[Participant 048]

Findings from the current studies (both quantitative and qualitative, Chapters 3, 4, 5) demonstrate severe impacts in many areas of the individuals' lives post-homicide. Regarding the estimation of psychological difficulties following homicidal bereavement (measured at the start of the EV intervention), findings were in line with previous research that demonstrated that prolonged and chronic effects are often reported, such as PTSD responses (e.g., Amick-McMullan et al., 1991; van Denderen et al., 2016; Rheingold & Williams, 2015; van Denderen et al., 2014), depression (e.g., McDevitt-Murphyet al., 2012; Rheingold & Williams, 2015) and CG (e.g., Rheingold & Williams, 2015; van Denderen et al., 2016; van Denderen et al., 2014). In fact, participants of this study reported severe levels of psychopathology[37]. Thus, all of the participants (n=67, 100%) met criteria for clinically significant levels of psychological difficulties (scoring >50), 56 (83.58%) screened positive for PTSD and 67 (100%) for CG. Again, this highlights the nature of this sample, given that all had previously had other forms of intervention but

[37] This was measured by: BSI, PDS and PG-13.

continued to have difficulties. It could be argued that making change with this group is an important indicator of the success of the EV programme.

The time since loss differed between individuals, but for the majority (n=59, 92.2%) it was longer than 12 months after the homicide at the time of the data collection and was not linked with the impact. Perhaps this demonstrates that psychological difficulties may not reduce automatically with time, hence professional support is needed. In fact, our findings were in line with a few previously conducted, where time since loss (more or less years since the homicide) did not impact on the individual's adjustment (e.g., McDevitt-Murphy; 2012; Rheingold et al., 2015).

Qualitative-based results collected at the same time point with 21 individuals (out of the 68 that took part in the quantitative element of the study), corroborate and extend the quantitative data. As shown by the quantitative data, individuals described having been changed by the homicide. Their narratives described a changed self and world post-loss mostly focused on their overall wellbeing and psychological issues (e.g., depressive and traumatic symptoms), strong feelings of anger and frustration, as well as strong physical reactions (e.g., headaches, tiredness, insomnia). The co-occurrence of symptoms and responses was actually reported very frequently (as it was in other studies as well; e.g., Rynearson, 1988) with this leaving the individuals with a perception of having an abnormal disease and *"going mad*". The co-occurrence of symptoms and responses was reported very frequently with this leaving the individuals with a perception of having an abnormal disease and "going mad". This finding is line with previous studies (e.g., Armour, 2003; Paterson et al., 2006; van Denderen et al., 2014).

Furthermore, fundamental assumptions (e.g., trust, unfaithfulness, safety issues) were changed by the homicide, with this increasing the individual's awareness about criminal activity and how ordinary people (such as themselves) can be affected by it. Previous literature has shown that those changes can actually contribute to the failure to meaning-making and reinforce the overall distress (Currier et al., 2006; Janoff-Bulman,

1992; Rynearson, 1988). On the contrary, the ability to find meaning about their experiences was linked with better adjustment among other studies (Armour & Umbreit, 2006; Gross, 2007; Johnson, 2010; Sharpe & Boyas, 2011). Alongside the psychological responses and overall maladjustment, financial difficulties were reported, with this being an additional source of stress for them. In fact, several interviewees have not been able to work since the event; this is similar to individuals described in previous studies (e.g., Malone, 2007b; Paterson et al., 2006; Thompson et al., 1988; Williams et al., 2012).

Finally and still related with the baseline measurements, overall low coping patterns were reported by the participants, both in the self-report measures and interviews conducted. Overall, the majority of the participants (n=60, 80.55%) scored below the clinical cut-off points. Moreover, when invited to think about coping strategies, their narratives appear to be vague and more focused on "*go day by day*" strategies. Despite that, adaptive and non-adaptive strategies were given as examples, such as: spending time with family, accepting help, avoiding places and/or activities, alcohol consumption, hiding feeling), which corroborates previous studies (e.g., Johnson, 2010; Miller, 2007b; Sharpe & Boyas, 2011).

Additionally, and thanks to the multi-waved design adopted in this research, it was possible to estimate how individuals progressed over time after the EV programme. Multilevel modelling analyses demonstrated that overall psychological symptoms[38], PTSD and CG statistically decreased over time when compared with the scores at baseline (described above). Nevertheless, it is important to note that despite the significant reduction of psychopathology, mean scores were still above the clinical cut-off point. This is perhaps unsurprising and such changes are notable given that the individuals attending the EV intervention had unmet needs following other interventions. Furthermore, the EV intervention does not aim to target specific clinical disorders nor deliver psychological treatment. Further, it would be interesting to undertake a longer term follow-up, for

[38] Measured by BSI.

example 2-5 years later to further estimate patterns of change (quantitatively), as this would provide a better understanding about how individuals adjust to their new realities (if at all) several years after the homicide and EV intervention.

Indeed, the qualitative element of this research included interviewing prior participants (2-5 years after the EV intervention) to gain a longer-term perspective of change (or not) in that timeframe. Thus, it has identified areas where individuals reported actual change over time and post-EV intervention, with this offering innovative information among the field. Further, participants described their increased understanding about their own and possible different emotional reactions, as well as realising that they are "*not alone*" or "*mad*".

Another actual change mentioned was coping. Here mixed results were found between the quantitative and qualitative elements. Thus, quantitative data showed that overall coping did not reach statistical significance over time. However, the cognitive and emotional domains (two of the subscales of the questionnaire) significantly increased between follow-ups. This might actually draw attention to the fact that learning and/or activating coping strategies are likely to require time. On the other hand, the qualitative data illustrated that the majority of individuals described themselves as more skilled to cope with their experience immediately after the programme. In fact, better understanding their psychological responses was not only referred to as an actual change, but also a new coping strategy for those individuals, with this being linked with better adjustment.

Other coping strategies included: better ability to communicate grief, as well as relaxation and creative techniques. It is interesting to consider the extent to which participant changes may also have impacted on those around them. Whilst for many, it was difficult to return to the 'cold reality', many did so feeling better able to understand how others' have differing grief reactions. An interesting further question, therefore, would be the extent to which there is a 'ripple' effect towards other family members who did not take part in the programme. Another thing to consider would be to see if those who attend

together (as some partners do), have better (or worse) outcomes than those who attend on their own.

In terms of support, it is notable that getting in touch with other EV participants was perceived as a useful strategy in the shorter term, but has less value as time goes by. Hence, it may be that finding new meanings or focusing on others works well for some people. Notably, a few interviewees (2-5 years post-EV intervention) even reported personal self-growth post-homicide, with this requiring further study.

Finally, and regarding resilience progression, mean scores were slightly higher at follow-up II when compared with baseline measurements, however this did not reach statistical significance. Previous research has not explored it among homicidally bereaved individuals and this would be an interesting domain to consider in the future. In this study, the fact that individuals have been supported previously might have also contributed for the satisfactory levels of resilience and/or it demonstrates that it might actually be possible to have a co-occurrence between resilience and psychological difficulties.

As outlined earlier in this thesis, maladaptation is only one of a number of different pathways and potential outcomes following a traumatic experience. Despite having been at significant risk, some individuals demonstrate an overwhelming ability to do well, showing resilience to difficult experiences, as has been empirically demonstrated (e.g., Luthar, 2003). Indeed, our participants reported both ongoing and severe psychological difficulties, as well as moderate levels of resilience (when compared to general population). This is actually an interesting finding and highlight the need for further investigate how resilience is measured among traumatised populations, in general and homicidally bereaved individuals, in particular.

Future research could explore whether different approaches to measure resilience (self-report questioners, interviews) differ among homicidally bereaved individuals. A study by Hamilton-Giachritsis, Marriott, Alves-Costa and Harrop (in preparation) has already suggested that it is important to consider not only the absence/presence of

psychopathology criteria as a definition of resilience, but across numerous domains of the individuals' lives, such as education/career/employment, interpersonal relationships, experiences of previous trauma exposure and informal and formal support. Thus, future studies could consider measuring resilience both quantitative and qualitatively, in order to better understand how homicidally bereaved individuals demonstrate and develop (if at all) their levels of resilience following the homicide. Furthermore, it would be relevant to recruit individuals seeking and not seeking professional support to estimate possible differences in terms of both groups and better inform clinical interventions to promote resilience post-homicide in the future.

Regarding the relationship with the offender (known vs. unknown) and potential effects on the homicide, outcomes research is very limited and inconclusive. For example, van Denderen et al. (2016) found that the relationship with the offender did not impact on the outcomes, but ongoing process and the conviction of the offender impacted on PTSD and CG scores (ongoing processes greater symptoms).

Our findings suggest that those individuals might need specific support due to the nature of the homicide. In fact, those individuals reported being hopelessness about future and reported higher levels of distress and psychological difficulties at all time points (both measured qualitative quantitatively). In fact, one of the qualitative studies demonstrated that dual grief was a factor that hold individuals back. Further, participants highlighted some particular issues that are likely to occur; namely, the emotional ambiguity felt regarding their relatives who committed the homicide. Moreover, participants reported family difficulties where changed relationships occurred or all contact ceased. Finally, individuals reflected on a perceived social stigma, as well as how the criminal justice system seems not to address the particularities of such experience.

Again, this is perhaps not surprising but does highlight that this group is unique and may require specific elements of support, related to this duality. Some studies have found

that intra-familial homicides increase the psychopathology and complexity of making sense/processing (Harris-Hendriks & Kaplan, 1993; Rynearson, 1984).

Further research should look into this duality more closely and could perhaps consider what practical difficulties these individuals report over time. They are left in a vulnerable position where they have to deal with the grief itself, as well as with potential family conflicts. Furthermore, they might require further psychological and legal advice support during the legal process and post-court hearings (e.g., they might wish to keep a relationship with the perpetrator).

3. Interventions and support needs – need for long-term support

"*When the trial is over, we start grieving*"

[Participant 045]

Regarding formal support post-homicide, a minority of the participants in this research had a past history of receiving interventions for psychological difficulties specifically, however the vast majority had some kind of support prior to the EV intervention (e.g., GP, police, Victims Support services).

When exploring individuals' perceptions of support, mixed findings were found. Qualitative data (Chapter 3) demonstrated overall positive satisfaction with the previous formal support received (e.g., Victims Support, Homicide services, police liaison officers), especially with practicalities (e.g., paying bills, planning meals) and with reassurance regarding their emotional responses. Nevertheless, limitations and suggestions for improvement were mentioned, mainly the need for support post-court trial, as this is seen as a critical period for increased distress and grief responses. Furthermore, and in line with these results, the longitudinal quantitative data (Chapter 4) demonstrated that despite the notable (and significant) decrease of psychological difficulties (i.e., overall psychopathology, PTSD and CG) over time and post-EV programme, individuals still reported clinical symptoms. Similarly, the longitudinal qualitative study (Chapter 5)

reflected on what barriers to recovery individuals report at follow-up assessments. Ongoing and fluctuation of symptoms was a central theme. In fact, and despite the positive change reported (e.g., increased understanding and coping, and even positive self-grown for some), individuals identified periods of ongoing distress and further support needs or knowing where they could seek support from, in case they needed to.

Importantly, the EV intervention aims to deliver informative workshops where new coping strategies can be accrued to help those individuals who are struggling the most (even after getting support from other services). Indeed, the EV intervention does not seek to deliver clinical treatments, but empower individuals with accurate information about overall psychological responses and adaptive coping strategies for them to begin a new journey. Interestingly, this will be 'enough' for some where they feel prepared to incorporate the homicide in their overall experience and therefore will show better adjustment. However, for others, the EV intervention will be revealed to be 'not enough' and additional support may be required. In fact, as found in the qualitative data (Chapter 3), two different 'shades' of adjustment were already demonstrated, where some individuals described their changed realities as their "*new normal*", whereas others described an inability to function and willing to "*go back to their normal*".

Unfortunately, only five participants interviewed during the EV intervention were followed-up 6-9 months later, therefore direct comparisons should be carefully taken. Nevertheless, those who were *more* positive before, also showed better adjustment later. It could be argued that personality traits and levels of resilience may actually play an important role in the individuals' responses following the homicide. However, this was not an aim of this research and it could be further explored in future studies. Personality and resilience could be explored by using clinical interviews, for instance. In terms of resilience and as it was demonstrated in our research, it would be important to reflect what resilience means for these individuals who have experienced potential traumatic experiences and perhaps develop a new tool able to capture their improvements over time

(even when non-significant from the statistical point of view), as this is likely to inform clinical practice (e.g., managing symptoms and expectations about their futures).

Moreover, for those five participants, the quantitative element of this research (Chapter 3) has also shown that their overall psychological difficulties significantly decreased over time (albeit not below clinical significance). Despite the very limited number of participants, this finding might inform about the likelihood for further support after the EV intervention. Indeed, if research can estimate how individuals with different personality and resilience patterns respond and adjust post-loss, this may help services predicting what psychological interventions/treatments would benefit them the most. However, this was not an aim of the current research and therefore not explored.

Still regarding the EV intervention, the qualitative domain of this research (retrospective and prospective interviews post-intervention; Chapter 5) captured the participants' perceptions about how the EV-programme contributed to their overall adjustment. The group nature of the intervention (8-14 individuals) was seen by almost all as extremely important, as they felt "*not alone*" or a "*unique case*". Other elements included the 1:1 sessions with the facilitators and the experiential EV-elements (therapeutic massages, art and photography). In addition, the residential nature seemed to have allowed individuals to have "*time and space*" " to "*put things in perspective*" and "*be away*" from their day-to-day routines and contexts. The extremely warm and nurturing environment provided by EV was highly praised by the participants. In fact, nearly all the participants stated how they appreciated having been looked after. Thus, nearly all of the participants mentioned that they would recommend the EV intervention to others with similar experiences of trauma.

In terms of comparisons with other interventions for homicidally bereaved individuals, as per other interventions identified in the systematic review (Chapter 2), EV is a small group setting, with psychoeducational regarding symptoms coping, and relaxation training. However, it is difficult to establish direct comparisons between EV

participants and individuals who participated in other studies, especially because it is unclear what support exactly was offered before. In fact, previous support might impact on the treatment/intervention successes. It would be important to objectively evaluate what support individuals received since the homicide (e.g., type of psychological intervention, frequency, duration), in order to better estimate patterns of change since they attended the EV intervention.

Furthermore, none of the studies testing interventions efficacy (including this research) included a control group (or waiting list control group) in order to estimate change more precisely. Additionally, the current research was unable to estimate what psychological elements and/or techniques are exactly crucial to promote change. In fact, the studies included in the systematic review performed were very diverse, not enabling the drawing of solid conclusions. Similarly, with the EV intervention, this was not controlled either. Importantly, this was not an aim when this project started, however it would be important to conduct randomised control trials where the different EV elements would be tested separately and compared. Finally, it is important to note that the few interventions accessed are internationally based (e.g., USA) and therefore it would be important to increase evidence-based interventions for homicidally bereaved individuals in this country.

Regarding individuals' perceptions of informal support, it is important to note that this was available for the most of them. However, this was not always seen as helpful. In fact, participants shared their concerns about individuals' (relatives and friends) apparent inability to *deal* with them by using avoiding strategies (e.g., avoiding talking about what happened), as well as not really knowing what to say. Previous studies have also noted that informal support is not always perceived as helpful (Goodrum, 2008; Mahat-Shamir & Leichtentritt, 2016). Thus, social awareness about how to respond to grief in general and to homicidal grief, in particular, could help to improve individuals' adjustment.

Finally, it is important to note that several individuals stated a strong belief about the inability to be fully comprehended and even supported by people that have not been

bereaved by homicide. Interestingly, this was not mentioned about the EV team where none of the team members have been homicidally bereaved. This should be explored further in future studies. In fact most therapists in any field do not have direct experience, nevertheless can be very able to help.

Escaping Victimhood

It is important to note some of the 'unique' elements of the EV intervention. Findings from the empirical studies suggested that individuals who took part in the EV intervention appear to be those who are struggling the most to adjust. Nevertheless, for the vast majority of the individuals, levels of psychological difficulties decreased post-intervention where the EV seemed to have had an impact. In fact, EV delivers a holistic intervention which includes a holistic approach by offering not only psychoeducational elements, but also the experiential activities (e.g., therapeutic massages, art and photography).

Firstly, the residential and nurturing environment offered by the EV programme seems to have a great impact on how individuals feel, as soon as they arrive at the venues.

They are provided with accommodation and dietaries and a team of skilled professionals are 'around' for four-days with them. In fact, this element was described as very important, as individuals felt look after and it gave them the opportunity to 'just' think about themselves away from their day-to-day responsibilities. Furthermore, the experiential components (therapeutic massages, experiential art and photography) were very often described as a part of the relaxing atmosphere, but also as a possible coping strategy to manage their stress levels (research should look at this further).

Secondly, the EV's psychoeducational element includes information about psychological responses, in specific traumatic reactions and how to deal with them. Some practical exercises are conducted to stimulate their ability to better identify symptoms and physiological reactions, for instance. In addition to that, it offers coping and management training where individuals are invited to consider potential protective and risk factors, as

well as describing what adjustment means to them. These activities are performed using videos with some ‘real life’ examples of how to active coping strategies or how adjustment might be a multidirectional journey with forwards and backwards.

Thinking about how this could be taken forwards, and considering the results for a four-day intervention, it might be important to understand how individuals would adjust over time if they had the chance to attend the EV intervention sooner. Considering the excellent job developed by National Homicide Service to help these individuals, as well as linking our findings with Casey’s report (2011), future research should look at how the different national welfare services support individuals and how those overlap (if at all) with the EV intervention. Finally, it could aim to build a national plan of action where all the services helping homicidal bereaved individuals could cooperate to the best interest of their clients.

Limitations of this research

The research conducted is one of the first empirical longitudinal mixed methods studies following homicidal loss. Nevertheless, several limitations need to be reflected on.

First, previous research has been conducted mostly in the USA-based and this thesis is UK-focused. Therefore, to draw direct comparisons between findings is a complex task, due to potential cultural differences, as well as criminal and health systems. Thus, more UK-based studies could emerge in the future to search for potential similarities and differences among studies and better represent the national realty in terms of care post-homicide.

It is also important to reflect about the diverse sample included in this research, where half of our participants reported knowing the perpetrator (i.e., the person who killed their loved ones). Indeed, this might have impacted on their narratives in terms of difficulties stated, help-seeking and adjustment experiences post-homicide. For that reason, future studies could consider analysing these sub-groups - using framework analyses, for instance.

Methodologically, and as it is expected when performing longitudinal studies, this study presented sample mortality over time. Nevertheless, efforts were made to insure rigor (e.g., statistical method used to analyse the quantitative data). Furthermore, and in spite of extensive efforts, recruitment of a control group failed (non-EV participants) and, thus, it was not possible to assess whether the effects at follow-up were directly linked to the EV intervention or spontaneous recovery. In line with this, it was not possible to control for type and amount of support individuals received over time (before and after the EV intervention) was not objectively measured. However, it should be noted that some participants had been bereaved as much as one or two decades prior to the programme, hence anecdotally suggesting that spontaneous recovery was unlikely. Thus, further research could seek to measure the exact support received since the homicide, nature of homicide and include personally and resilience clinical interviews.

Regarding the study design, quantitative data to estimate rates of overall psychological difficulties, PTSD and CG, as well as coping and resilience patterns were based on self-report questionnaires and this might overestimate psychological symptoms (Engelhard, Arntz, & van den Hout, 2007; Kristensen et al., 2012). Despite, the good level of consistency between qualitative and quantitative findings, it is important to note that the majority of the participants informally stated that their preference was to talk in interviews (rather than fill out questionnaires), and this could be considered in future studies.

In addition, EV had concerns about the level of testing and ensuring participants were not disengaged at the beginning of the programme due to the research. Therefore, participants were only asked to complete one measure post-intervention (BSI) following EV's suggestion, meaning the other domains assessed (PTSD, CG, coping and resilience) were only measured in three waves rather than four. Moreover, and despite the quite unique design of the research, a longer quantitative follow-up period (e.g., 2 – 5 years) was not possible to undertake due time limitations.

This study included mostly females, hence it was not possible to estimate possible differences among genders (if at all). Finally, the EV participants seem to constitute a group of individuals who find it harder to adjust, as other professional support was offered before. Therefore, the research protocol could be taken further by other national services to better estimate potentially differences.

Finally, with the regards to the qualitative data, efforts were made to ensure rigor and reliability (e.g., blind coding was conducted by an external coder). However, the research focus was on EV participants and further generalisations are limited.

Regarding the samples included in this research, the majority of the participants were UK citizens, predominantly of western cultures. Therefore, it is unknown whether the results could be generalizable to other non-western cultures, where rates of crime tend to be higher and support limited (South Africa, Brazil). Indeed, and as explored previously in this thesis, it would be important to understand how homicidal bereaved individuals

respond post-homicide and how they tend to adjust over time, considering that they live in distressing and violent environments (a somewhat different context to the UK or other European countries). Besides, it is unclear if our results could also be generalised to collective acts of homicide, such as war and terrorist acts.

Research recommendations

Despite the limitations outlined above, this research contributed to the overall knowledge about the beneficial effects of the EV intervention, as well as about homicidal bereavement experiences form both research and clinical point of views. Table 1 offers a summary of recommendations to improve the EV programme, overall clinical practice and policy.

This is one of the first longitudinal mixed methods studies internationally and the first one in the UK, to the best of the author's knowledge. In fact, there is a lack of national research looking at experiences of homicidal bereavement and this research also hopes to stimulate future UK-based studies and discussions; as suggested by Casey (2011), it is important bereaved families be provided with an "integrated service". This research has also proved that homicidal bereaved individuals report ongoing and severe psychological difficulties that may last for years without spontaneous recover, and that they need and deserve to receive counselling, trauma support and overall mental health care.

Thus, one of the main findings of this research is that (perhaps unsurprisingly) individuals bereaved by homicide will report different and ongoing needs as the time passes by and our heath and legal systems could be *more* mindful of that. In fact, their needs in the aftermath (where they seek for help in order to understand he court and police processes, day-to-day practicalities, for instance) will be different at different times. When the "*court is over*", individuals start grieving and trying to process their horrendous experience. Even three or four years post-homicide, they may not still fully understand everything that happened or why it happened to them. The key message is that some homicidally bereaved individuals will perhaps need to be followed-up regularly and their needs reassessed multiple times; welfare professionals need to be mindful of that. This is in line with what described in by Casey (2011):

> *As the Victims' Commissioner I understand that we cannot make up for the damage wrought upon these families by those that have killed their loved ones. However, as*

a society it should not be beyond our reach to ensure that bringing that perpetrator to justice involves a fair process that does not have to wreak further havoc upon people when they are at their most vulnerable – and that we do all that we can to give them the ongoing care that they deserve."

Secondly, this research has also highlighted that homicidally bereaved individuals will inevitably be changed by the homicide. As explored in both quantitative and qualitative empirical studies, they report several changes, such as psychological and physical difficulties, professional, financial and family issues. Their narratives describe a changed identity in a new reality where their loved ones are suddenly no longer there. This was strongly linked with their new and old normal ways of thinking and being in life and is likely to inform clinical practice. Indeed, it appears that homicidal bereaved individuals could benefit from psychological interventions where meaning-making is explored. This could give them the opportunity to understand that they are (in fact) changed individuals that need to re-lean how to live in a changed reality/new normal rather than fighting to "*go back to their normal*".

Thirdly, this research has considered not only deficits post-loss (psychological difficulties), but also measured coping and resilience patterns. In fact, this is something that not many other studies have included before, especially in terms of resilience patterns. As explored in the discussion of this thesis, resilience is mediated through individual and situational factors and that relatively short-term psychological difficulties can be considered a 'normal' bereavement response; for that reason, DSM-V excludes individuals bereaved for less than two months for a diagnosis of major depressive disorder (APA, 2013). Furthermore, a complete absence of distress following a loss could also be considered an atypical outcome that might impact negatively in the future (Middleton et al., 1993).

Finally, it has been noted that maladaptation is only one possible outcomes following many forms of trauma (Futa, Nash, Hansen, & Garbin, 2003) and some

individuals demonstrate an overwhelming ability to cope and show resilience (Kalisch 2015; Mancini, 2009). Interestingly, therefore our participants showed moderate to high levels of psychological difficulties but also some level of resilience. To the best of the authors' knowledge, to date there has been no study conducted specifically on resilience among homicidally bereaved individuals. Thus, this could be further researched in future research, as this research highlighted the need for a more structured coping/planning-training approach among homicidal bereaved individuals.

Regarding mixed methods used in this research, it was proven to be an effective design to access to the individuals' experiences post-loss. Therefore, it could be recommended design for future projects.

With regards to the EV intervention, it was empirically demonstrated to be helpful for the majority of the individuals. Therefore, this might offer a good example to be combined with what it is already offered in this country. Thus, some of the EV intervention elements (e.g., psychoeducational, experiential activities) can also inform other, similar services, in order to hope for a *more* standardised support and care in the UK, the need for which was highlighted by Casey (2011).

Table 1. Recommendations for practice and policy.

EV should consider the inclusion of:	**Clinical practice / services**	**Policy**
▪ Goal setting (return home and more long term) and how this will be addressed during the intervention ▪ More coping, resilience-based training ▪ Exercises to increase future planning ▪ Information about the Criminal Justice System ▪ Offering support to deal with social media (e.g., intrusion and deactivation the victim's accounts) ▪ Preparing for the reminders (e.g., special dates) ▪ Individual report to send back to referrer with some areas that might need further support ▪ Mapping and establish contact between individuals and other services (if needed)	▪ Individuals appreciate having help with day-to-day practicalities in the aftermath ▪ Psychoeducation about trauma, grief, criminal justice system and meaning-making are crucial for individuals adjustment ▪ High levels of psychopathology and possible ongoing psychological difficulties should be expected and this might require long-term clinical interventions ▪ Clinical interventions should consider trauma, grief and meaning elements ▪ Residential interventions might offer a good alternative for some individuals, as they feel looked after and this gives them the 'space' to understand their experiences ▪ Coping, resilience and growth should be included in case formulation and set as intervention goals	▪ Funding for longer support (post-court hearings) should be available ▪ Development of a national protocol where key information could be shared by the different professionals (streamline process): o Rigorous assessment tool where potential protector and risk factors could be identified (in early stages) o Type and avenues of support for homicidal bereaved individuals o Standardised 'plan of action' and individual formulations at different times (i.e., post-homicide, during the criminal & legal proceedings, before, during & after court) o Medical information and previous support ▪ Specialised training for those working with

	▪ Group interventions with individuals with similar experiences of loss ▪ Dual grief (close relationship with victim and offender) might result in more distress and more practical issues	homicidally bereaved individuals ▪ Social awareness campaigns about how to respond to bereavement and homicidally bereavement, in particular ▪ Media: awareness about how the stories can impact on the individuals' lives should be considered ▪ Promote knowledge exchange (KE) among national researchers, clinicians and other professionals (e.g., EV and research team)

Future research

This research identified that the evidence-based studies with homicidally bereaved individuals is still somewhat limited and future research is required to ensure the best (possible) support for those left behind. Specifically, future research could include:

- Multi-wave studies (follow-up periods >2 years) could be conducted to better understand how individuals progress over time, hence this research has demonstrated that individuals report different needs at different times, and this is something that should be considered in clinical practice.
- Mixed methods studies (quantitative and qualitative elements) are often seen as very powerful to describe the social reality understudy. In fact, the design adopted in the current research was very effective and allowed an in-depth understanding about the individuals' experiences post-homicide. Indeed, quantitative or qualitative studies per se would not have generated the same amount of data in terms of the participant' psychological difficulties, coping and resilience patterns, as well adjustment and their unmet needs.
- Studies could consider when possible the inclusion of control groups or repeated measures comparisons designs to better estimate symptoms progression. Furthermore, community groups (not seeking formal support) could also been considered to estimate how those differ (if at all) from the clinical populations and among children and adolescents.
- Randomised clinical trials could be implemented in order to test possible treatment-efficacy and cost-effectiveness differences between different interventions. In fact, it would be interesting to understand if several variables impact on the treatment outcomes (e.g., number of sections, psychological treatment/intervention).
- Alternative indicators to evaluate psychopathology (e.g., biomarker indicators) could be included in future research, as this could improve the accuracy of diagnosis (e.g., PTSD, depression, anxiety) and, in turn, improve patient outcomes.

- Studies could also consider pre-homicide information: such as trauma exposure, psychological difficulties, previous support/treatment (e.g., intervention, drug-based treatments), personality traits, social interactions and worldviews. This could improve understanding regarding the individuals' responses post-homicide and better inform what psychological interventions could be the most effective considering the individuals' characteristics. Furthermore, it would be important to estimate resilience, coping and growth patterns, as these indicators are not very often included and could be bring some awareness about how clinical interventions could address it.
- To explore individuals' perceptions about formal and formal support offered by individuals who do or do not themselves have homicidal bereavement experiences could be considered in future research, as this was noted by some of our participants who felt that they could not feel be fully understood and helped by individuals who have not been bereaved by homicide.
- Research is needed to better understand how dual grief cases (close relationship with the victim and perpetrator) impact on how individuals progress over time, as well as how this might be a factor that requires 'special' support post-homicide.
- Future studies could also further understand the individuals' perceptions of police support during the case investigations, as this could inform practice and police training to better deal with homicidally bereaved individuals/families.

Conclusion

The current research suggested that an experience of homicidal bereavement is a "*unique*" experience with the homicide itself and the context post-loss likely to contribute to chronic and prolonged periods of distress where psychological difficulties, professional, financial and social issues may co-occur, with this being in line in previous studies. Furthermore, this thesis extended the somewhat limited knowledge looking at individuals' progression over time, as well what psychological and societal elements appear to contribute to their overall (Mal)adjustment.

Throughout this thesis, participants described how the EV intervention was crucial for a better adjustment to their "*new reality*". Thus, some of EV elements (also shared in other psychological interventions reviewed) such as the residential, group and psychological nature can actually help those individuals who are struggling the most. Nevertheless, and despite the significant decreases in symptomatology, as well as positive changes described over time and following the intervention, clinical symptoms were still reported. Those results need to be read taking into consideration the fact that the EV intervention does not provide personalised clinical treatment, and therefore further structured support might be required for some of the individuals.

This research has inevitably some limitations that need to be considered, including the lack of a control group. In fact a community group (seeking and not seeking) treatment could bring some more insights about not only the EV intervention efficacy, but also about potential personal variables that might moderate the impacts. Nevertheless, this is one of the first longitudinal mixed methods studies conducted internationally and the first one in the UK, thus this might stimulate further research and clinical practice to help individuals in their goal to be begin "*looking up again*".

Personal Reflection

From the process of critical self-reflection about the research undertaken as part of this PhD, my own perspectives about this social reality have changed. Indeed, since I started having contact with the topic through reading the literature, and more importantly when I started having contact with the homicidally bereaved individuals, some questions (not really part of the research aims) arose.

Firstly, listening to the participants stories was (perhaps unsurprisingly) difficult. In fact, the data collection setting used in this research was somewhat unusual. As previously mentioned, EV offers a four-day residential intervention, where I was (fortunately) able to attend and it was in this setting that 'face-to-face' assessments took place.

Those four days (multiplied by eight – the number of workshops from which I collected data) were for me, as a junior researcher, extremely rich. I had the opportunity to better understand how those individuals "see" and "feel" their reality. During the interview process, I had to find a balance between my clinical and research backgrounds. This was not always easy, especially because as a clinician I wanted to reinforce their changes and co-construct strategies to promote their adjustment… but, this was not my role.

Alternatively, I used my listening skills and showed empathy guiding the interviews. The end of those sessions were (in most of the cases) surprisingly positive: the smiles in their faces and statements of gratitude to us [EV and research teams] were definitely reassuring and reminded me of the reasons as to 'why' I have chosen my career.

The last day of the EV programme always felt bittersweet for me. On the one hand, I was very happy with another successful data collection session completed and almost wanting to immerse myself into the analysis of the data straight way. Furthermore, seeing our participants leaving the venues smiling and looking up (the opposite to what had happened when they first arrived) was definitely impressive to witness. On the other hand, my journeys home and the following day/days were challenging.

After the first group of data collection, my supervisory team and I decided that it would be a good idea to engage with clinical supervision, due to the potentially traumatising topic that I was working on. I believe that this is something that should be considered more often when junior researchers start working with those individuals exposed to adverse and extreme violent experiences.

I have to admit that the clinical supervision was overall helpful for me. However, I quickly understood that it would be a preventive strategy, as the more I worked with 'our' individuals the more I realised that I was ready to cope with eventual negative side effects. For me, it was almost a mission. I was going to be their voice and therefore every step of this research was done thinking of them (and many others sharing similar experiences).

…and so it was, after collecting prospective and retrospective data for over two years, the findings were analysed and written ready to be shared and hopefully stimulate academic, clinical and policy discussions.

Finally, this research made me realise how easy it is to fall into categories, labels and rules mostly offered by western culture/society. Here, the '*normal'* and '*abnormal'* seem to describe and perhaps moderate how we respond to bereavement, in general and homicidally bereavement in particular.

As previously stated, the majority of individuals seem to adjust relatively well to a new reality post-loss (especially non-violent deaths). It is also true that violent-deaths seem to bring '*different*' or '*more intense*' reactions. I wonder how 'abnormal' the responses post-homicide really are. I also wonder if the notion of '*moving on'* is the right approach to undertake. These questions have made me realise and come to hypothesise that perhaps homicidal bereavement is an experience in which emotions, cognitions, behaviours and ones identity will be inevitably be changed. It would be a surprise if such a powerful experience *did not affect* these individuals in the some way.

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Appendices

Regarding the EV intervention, following an introductory session, the first three mornings are spent in group psychoeducational sessions. In the afternoons, individuals are invited to engage with the available therapeutic massages, art and photography sessions. They are also offered one to one sessions with any of the EV facilitators and/or leaders.

Considering the psychoeducational nature of their intervention, the sessions include a description of the psychological difficulties that are likely to occur following such potentially traumatic experiences. In terms of strategies used to deliver the intervention, facilitators invite the individuals to engage in small group exercises to stimulate their awareness and ability to better identify symptoms. Furthermore, symptoms management and coping training are included as well. With regards to the mentioned experiential activities (therapeutic massage, photography and art produced during the programme), they are included in the EV programme and aim to expose individuals to new coping strategies, and use a part of the brain which the trauma has overwhelmed previously (creativity).

It should be stressed that the whole programme is residential and therefore the social aspect, meals and evenings are important in providing the supportive and nurturing aspect which the participants found so beneficial to aid their recovery. Four of the Facilitators (all professionals) stay for the whole programme and are present and available during the evenings and necessary for any crisis to be dealt with promptly and effectively. A follow up day, non-residential is held about 2 months later, with a focus on reviewing the material and ‘checking in’ with each other as to what worked and what was difficult on returning home, support is given as necessary. The remainder of that day has a future focus to encourage personal plans. Directories of information based on the participants Police and Crime Commissioner Region are also distributed and notes for referrals on or signposting made as requested.

It is important to mention that Filipa Alves-Costa participated in all of the psychoeducational sessions and observed other sessions. Data collection took place at the beginning of the intervention (day one) and following the final psychoeducational

intervention (day three). Regarding the qualitative interviews, participants were invited to sign-up to do the one-to-one interview with Filipa when they felt it was the "right" time for them.

Appendix B: Information Sheet for Participants

Information Sheet for Participants

(Prospective Study**)**

Title of the research project: *Homicidal bereavement in the UK: listening to and understanding stories from those bereaved through murder and manslaughter*

We would like to invite you to take part in a research study. Before you decide if you want to take part, you need to understand why the research is being done and what it would involve. Please take your time to carefully read the following information sheet. If you have any questions, please ask us.

Who are we?

- Filipa Alves da Costa is a PhD researcher at the University of Bath.
- Dr Catherine Hamilton-Giachritsis is a HCPC registered Forensic Psychologist and Clinical Psychologist. Currently she is Reader in Clinical Psychology at the University of Bath.
- Dr Sarah Halligan is Reader in Developmental Psychopathology at the University of Bath.

What is the purpose of the study and why I am asked to participate?

This study investigates the Escaping Victimhood (EV) programme, in order to learn more about what is useful for participants and what helps them cope and recover. There is relatively little support for individuals who have been bereaved through murder or manslaughter. The EV programme is the only programme available at present, and it is very important to establish if it works and what works best.

Therefore, we are inviting all EV participants in all workshops aged 18 years and over to take part in this study.

What will you be asked to do?

If you would like to take part we will ask you to sign a form that says you are happy to be involved, that you understand what you are being asked to do and that you are aware you can stop at any time.

We will ask you to complete several questionnaires and to do a one-to-one interview. The study will entail:

- Questionnaires (during the workshop)
- Questionnaires (4-6 weeks after the workshop; by post)
- Questionnaires (6 months after the workshop; by post)

Do I have to take part?

Your participation in this study is completely voluntary. If you decide to participate, you are still free to withdraw at any time during each testing session, without giving us a reason. Just tell us that you would like to withdraw – either in person or by using the contact details given below.

What are the possible benefits and risk of taking part?

There may be a direct benefit to you (you will have the opportunity to speak about topics that are important to you) and also this study is important for our understanding of EV effectiveness. There is no risk involved. However, you may find some of the questions upsetting or very personal. You do not have to answer any questions you do not want to. If you are upset and want to talk about it, you can talk with the researcher or one of the EV keyworkers.

What happens to the answers I give?

All information collected as part of this study is fully confidential. All of the forms will only have your code on (only the researcher will know which person has which code) and the list of codes and names will be stored in a locked filing cabinet and/or on a password protected file. In reporting the study, all of the answers will be reported together as a group so, it will not be possible to identify an individual. Any names, place names or identifying features will all be changed to make sure no one will be able to identify you.

Who is organising the research?

This study is being led by Dr Catherine Hamilton-Giachritsis (Reader in Clinical Psychology at the University of Bath) and Filipa Alves-Costa (PhD student at the University of Bath). It is being carried out at the request of the EV charity so that they can ensure their work results in the greatest effectiveness for the victims and their families. The

study has been approved by the University of Bath, School of Psychology Ethics Committee.

What if there is a problem?

If you have any questions, please ask Filipa Alves-Costa or Clifford Grimmason (EV) in person or by email; or Dr Catherine Hamilton-Giachritsis or Dr Sarah Halligan at the address below.

Who can I ask for further information about the study?

If you would like any more information about this study then please contact the researcher:

Filipa Alves-Costa email f.alves-costa@bath.ac.uk or via phone [redacted]

You can also contact her supervisors:

Dr Catherine Hamilton-Giachritsis email c.hamilton-giachritsis@bath.ac.uk or via phone 01225 384861

Dr Sarah Halligan email s.l.halligan@bath.ac.uk or via phone 01225 386636

Thank you for your reading this information!

Appendix C: Consent Form for Participants

Consent Form for Participants

(Prospective Study)

Title of the research project: *Homicidal bereavement in the UK: listening to and understanding stories from those bereaved through murder and manslaughter*

I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

1) **I understand that my participation is voluntary and that I can withdraw at any time without giving any reason. I understand that I can choose not to answer questions.**

2) **I understand that data collected during the study will be made anonymous unless information comes to light to suggest that they or another individual may be at risk of, or are currently experiencing, significant harm. Moreover, data collected may be looked at by the research team from the University of Bath.**

3) **I understand that data obtained as part of this study will be kept for a minimum of 10 years after completion of the study (stored in a locked filing cabinet at the University of Bath).**

   A) I agree to take part in

The questionnaires	YES / NO
The interview	YES / NO

   B) I agree to let the research team have access to the information previously collected by the Escaping Victimhood Team (i.e., Address; Country of birth; Phone and E-mail contact; Occupation; Medical Background; Information about the event). **This information will ONLY be used in order to establish the most appropriate means of delivering the programme. Contact details will ONLY be used by the researcher, in order to communicate with the participants. None of the information will be passed to third parties.**

   YES / NO

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

Appendix D: Debriefing Form for Participants

Debriefing form

(Both Retrospective and Protective Studies)

Title of the research project: *Homicidal bereavement in the UK: listening to and understanding stories from those bereaved through murder and manslaughter*

Thank you for agreeing to participate in this study! This study is an investigation into individuals who have been bereaved through murder or manslaughter. The residential programme aims to help individuals to 'cope and recover' from their traumatic experience, taking an holistic approach to helping victims of traumatic crime, specifically struggling to move forward following the death of a family member in traumatic circumstances.

We invited people during our workshops to take part in our study. However, if an individual does not wish to have their data included in the research, they may still participate in the programme. All data and information will be confidential and anonymous unless information comes to light to suggest that they or another individual may be at risk of, or are currently experiencing, significant harm.

Moreover, the list of names and case numbers will be stored in a locked filing cabinet and/or held in a password protected file at the University of Bath. Individuals will not be able to be identified in any publications of the findings (all data will be presented in group format with no individual person or family identifiable in any way).

If you have any complaints, concerns, or questions about this research, please feel free to contact, Filipa Alves-Costa (f.alves-costa@bath.ac.uk) or Clifford Grimmason (EV; [redacted]). Alternatively, you could also contact Dr Catherine Hamilton-Giachritsis (email: c.hamilton-giachritsis@bath.ac.uk or via phone 01225 384861) or Dr Sarah Halligan (s.l.halligan@bath.ac.uk or via phone 01225 386636).

Thank you again for helping us with this research

Invitation, Information Sheet and Consent form for Participants

(Retrospective Study)

Dear participant,

We hope you are well and wish you all the best for 2016.

We are writing in order to know how you are doing after your participation in the Escaping Victimhood programme. For that reason we would like to invite you to take part in a research study (*Homicidal bereavement in the UK: listening to and understanding stories from those bereaved through murder and manslaughter*) that has been running since September 2014 at the University of Bath in cooperation with Escaping Victimhood Charity. Before you decide if you want to take part, you need to understand why the research is being done and what it would involve. Please take your time to carefully read the following information sheet. If you have any questions, please ask us (contacts are provided below).

Many thanks in advance for giving us your time!

Who are we?

- Filipa Alves-Costa is a PhD student at the University of Bath.
- Dr Catherine Hamilton-Giachritsis is an HCPC registered Forensic Psychologist and Clinical Psychologist. Currently she is Reader in Clinical Psychology at the University of Bath.
- Dr Sarah Halligan is Reader in Developmental Psychopathology at the University of Bath.

What is the purpose of the study and why you are asked to participate?

This study investigates Escaping Victimhood (EV) programme, in order to learn more what is useful for participants and what helps them cope and recover. There is relatively little support for individuals who have been bereaved through murder or manslaughter. The EV programme is the only programme available, and it is very important to establish if it works and what works best. Therefore, we are inviting EV participants who took part in the intervention prior to 2014 to take part in this study.

What will you be asked to do?

If you like to take part we will ask you to sign a form that says you are happy to be involved, that you understand what you are being asked to do and that you are aware you can stop at any time.

We will ask you to do a one to one interview. The study will entail:

- one session (phone/skype) no longer than 50-60 minutes.

Do you have to take part?

Your participation in this study is completely voluntary.

What are the possible benefits and risk of taking part?

There may be a direct benefit to you (you will have the opportunity to speak about topics that are important to you) and also this study is important for our understanding of EV effectiveness. There is no risk involved. However, you may find some of the questions upsetting or very personal. You do not have to answer any questions you do not want to.

What happens to the answers you give?

All information collected as part of this study is fully confidential. All of the forms will only have your code on - only the researcher will know which person has which code and the list of codes and names will be stored in a locked filing cabinet and/or on a password protected file. In reporting the study, all of the answers will be reported together, as a

group so it will not be possible to identify an individual. Any names, place names or identifying features will all be changed to make sure no one will be able to identify you.

Who is organising the research?

This study is being led by Dr Catherine Hamilton-Giachritsis (Reader in Clinical Psychology at the University of Bath) and Filipa Alves-Costa (PhD student at the University of Bath). It is being carried out at the request of the EV charity so that they can ensure they work in the best possible for victims and their families. The study has been approved by the University of Bath, School of Psychology Ethics Committee.

Who can you ask for further information about the study?

If you would like to take part of this study or you want any more information about it please contact:

- Filipa Alves-Costa: email: f.alves-costa@bath.ac.uk or via phone: [redacted]
- Dr Catherine Hamilton-Giachritsis email c.hamilton-giachritsis@bath.ac.uk or via phone 01225 384861
- Debra Clothier: email: [redacted] or via phone: [redacted]

Note: If you would like to take part in this study please sign the consent form and post it back.

Thank you for your reading this information.

Consent Form for Participants

(Retrospective Study)

Title of the research project: *Homicidal bereavement in the UK: listening to and understanding stories from those bereaved through murder and manslaughter*

I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

4) **I understand that my participation is voluntary and that I can withdraw at any time without giving any reason. I understand that I can choose not to answer questions.**

5) **I understand that data collected during the study will be made anonymous unless information comes to light to suggest that they or another individual may be at risk of, or are currently experiencing, significant harm. Moreover, data collected may be looked at by the research team from the University of Bath.**

6) **I understand that data obtained as part of this study will be kept for a minimum of 10 years after completion of the study (stored in a locked filing cabinet at the University of Bath).**

C) I agree to take part in

The interview (by phone/skype) YES / NO

D) I agree to let the research team have access to the information previously collected by the Escaping Victimhood Team (i.e., Address; Country of birth; Phone and E-mail contact; Occupation; Medical Background; Information about the event). **This information will ONLY be used in order to establish the most appropriate means of delivering the programme. Contact details will ONLY be used by the researcher, in order to communicate with the participants. None of the information will be passed to third parties.**

YES / NO

Name of Participant Date Signature

Name of Researcher Date Signature

Interview Schedule I

Interview Schedule

(During the EV intervention)

ID:

Date:

Thank you for giving us your time. As I have explained before, we are undertaking research together with EV, in order to better understand the individuals' experiences, as well as to understand if EV achieves its aims of helping people to cope and recover following a homicidal bereavement experience. The aim of this interview is to help us learn:

- more from people individually about how they have tried to cope and recover from traumatic experiences.
- ask few questions about the EV programme. Please let me know if you feel uncomfortable or if you do not understand some question.

As you probably remember from filling out questionnaires during the workshop, you can choose not to answer any question you don't want to – or you can ask me to repeat a question or make it clearer. If you do not mind I will record our conversation – this will help me ensure that I get all of your words right as it is very important to hear things in your own words. However, only I will have access to the recording and I will delete it as soon as I have typed it up. The transcript will be shared with the research team but it will not have your name on it and I will change any identifying features as I type it up so no one will know it is you. It may seem strange at first, but I find people quickly forget they are being recorded. Many thanks again. Are you ready to begin?

1. I would like to begin by asking you what brings you here? / What made you choose to come here?

2.

   a. Could you tell me how you heard about the EV programme?
   b. Were there things that nearly stopped you coming? (If so, how did you overcome them?)
   c. What are you hoping to get out of this programme?

3. Losing someone special through murder or manslaughter is obviously very traumatic. When this happens to a family, which areas of their lives do you think are most affected for that family? Can you tell me more about that?

4. Do you have any thoughts about who it usually happens to, when or why? (explore this with them).
   a) Do you think it was similar or different in your own experience?

5. What changes have you noticed in yourself since your loss?
   a. life quality/satisfaction?
   b. Family relationships
   c. Physical or mental heath
   d. Jobs and employment
   e. Social life
   f. Financial impact
   g. Motivation to do “things”

6. How do you make sense of this loss in your life?

7. How much does your life revolve around this experience?

8. Does the world seem like a dangerous place to you?

9. Does that perception about the world make you feel alone?

10. What kind of things do you do to cope or to manage that situation? Are they helpful/useful for you?

a) Family
b) Friends
c) Job
d) Groups (e.g., social/ religious)
e) Events

11. Have you changed in the way you cope with your problems and manage your distress? Is there something you would like to do differently? (if yes, what blocks them?)

12. Since your loss, have you been supported by anyone? (see what they say but then prompt re family/friends/professional groups/charities, etc.
    a. Which ones?
    b. How you feel about the help you have had (or not had)?

13. Have you any experiences of the Criminal Justice System or other agencies? If yes, when? What happened? Would you like to tell me more about these experiences?

14. In the past, has anything else bad happened in your life apart from this loss that you would be willing to discuss?

15. If we look at the EV programme, have you noticed any changes in yourself since you came? (make a note how many days they have been on the programme)
    a) If yes, can you give me some examples?
    b) What do you think you have found helpful?
    c) Is there anything you didn't find helpful or even found made things seem worse?
    d) Is there anything you would have liked to have had / done on the programme that wasn't here?
    e) What do you think you would change about it if you could?
    f) If you had to describe it to someone, what would you say about it?
    g) Would you recommend it to someone else?

16. Finally, have you thought about what will be your needs/desire for other sources of support when the EV programme is finished?
    a) in the short term

b) In the long term

c) Do you feel that support may be available – and will you feel able to seek it?

Thank you very much!

Follow-up Interview

(6-9 months and 2 to 5 years following the EV intervention)

ID:
Date:

Hello xxx. This is Filipa here.

Thank you for giving us your time today and for agreeing to let us interview you. As you know this interview is important to help us learn more about traumatic experiences and how people cope and recover from these experiences. We are interested in learning how things may have changed for you since you took part in the EV programme. Moreover, we would like you to ask few questions about the EV's programme. Please let me know if you feel uncomfortable or if you do not understand any question. As explained before, and if you do not mind, I will record our conversation (to help me to do my job), but I am the only person that will have access to it and it will be password protected. As soon as I have typed up the notes (without any names or things that could identify you), I will delete the recording.

Do you have any questions? Many thanks, again. Are you ready to begin?

1. I would like to begin by asking you some questions about the programme.

- **a.** Could you please begin by telling me what you think about EV's programme now several months/years after completing it?
- **b.** What were your expectations before you had taken part?
  - **i.** Have these expectations become reality?
- **c.** How helpful/useful was it for you?
  - **i.** Was there something in particular you found useful at the time?
- **d.** Any particular skills you have learned and are using regularly? Why?
- **e.** Are you keep in touch with others participants?

i. Was there something that at the time you thought WASN'T useful but as time has passed, you realise it was?

ii. Were there any parts you didn't like or didn't find useful? (now or then?)

f. Have you noticed any changes in yourself since then?

i. (prompt with physical health, mental health, employment, family, etc.)

g. Would you recommend EV's programme to others with similar experiences than yours?

i. (If either yes or no, find out why)

h. If you could change something about the EV programme, what would it be?

2. Now, I wonder if we can think about you and how you are feeling.

a. Has the way you coped with what happened changed since you took part in EV's programme?

b. What ways did you cope before and what do you do now? prompt with:

i. Family

ii. Health/mental health/psychopathology

iii. Professional life

iv. Social life

v. Financial condition

vi. Motivation to do "things"

vii. In the way you cope with your problems and manage your distress

3. Since you went to the EV programme, have there been changes in terms of:

a. "How much your life revolves around the traumatic experience"?

b. If the world seems like a dangerous place to you?

c. If that perception about the world makes you feel alone?

4. Since your participation in EV's programme, have you been supported by other organisations (e.g., NHS, GP, support groups)?
    a. Which one/s?
    b. Did you feel able to ask for additional support or how did you end up gaining this support?
    c. What is your experience of that support? (helpful/not helpful)
5. Have you had any experiences of the Criminal Justice System or other agencies? If yes,
    a. when?
    b. What happened?
    c. Do you feel able to tell me more about these experiences?
    d. Why do you think that this happened?

6. Now, I would like you to ask what will be your needs/other sources of support.
    a. Short term
    b. Long term

7. How do you feel about the future? Are there any areas you think we haven't covered or things you want to say?

Thank you very much for your interview.

Appendix H: Ethical approval

Dr Michael J Proulx
Chair, Psychology Ethics Committee
Telephone +44 01225 385963
Facsimile +44 01225 386752
E-mail: psychology-ethics@bath.ac.uk

UNIVERSITY OF BATH
Department of Psychology
Bath BA2 7AY · United Kingdom

5 June 2015

Dear Filipa Alves-Costa

Reference Number 14-186
p
I am writing to confirm that the Psychology Ethics Committee has provided full ethical approval for the above project "Escaping victimhood: An evaluation of the victims" on 4 September 2014.

Best wishes with your research.

Dr Michael J Proulxp
Chair Psychology Ethics Committee

Review title and timescale

1 Review title

Give the working title of the review. This must be in English. Ideally it should state succinctly the interventions or exposures being reviewed and the associated health or social problem being addressed in the review. Psychological interventions with homicidally bereaved individuals – a systematic review

2 Original language title

For reviews in languages other than English, this field should be used to enter the title in the language of the review. This will be displayed together with the English language title.

N/a

3 Anticipated or actual start date

Give the date when the systematic review commenced, or is expected to commence.

01/07/2016

4 Anticipated completion date

Give the date by which the review is expected to be completed. 30/09/2017

5 Stage of review at time of this submission

Indicate the stage of progress of the review by ticking the relevant boxes. Reviews that have progressed beyond the point of completing data extraction at the time of initial registration are not eligible for inclusion in PROSPERO. This field should be updated when any amendments are made to a published record.

The review has not yet started ×

6 Named contact

The named contact acts as the guarantor for the accuracy of the information presented in the register record. Filipa Alves-Costa

7 Named contact email

Enter the electronic mail address of the named contact. F.alves-Costa@bath.ac.uk

8 Named contact address

Enter the full postal address for the named contact.

10 West, University of Bath Claverton Down Rd, Bath, North East Somerset BA2 7AY

9 Named contact phone number

Enter the telephone number for the named contact, including international dialing code.

[redacted]

10 Organisational affiliation of the review

Full title of the organisational affiliations for this review, and website address if available. This field may be completed as 'None' if the review is not affiliated to any organisation.

University of Bath

Website address:

http://www.bath.ac.uk/staff/

11 Review team members and their organisational affiliations

Give the title, first name and last name of all members of the team working directly on the review. Give the organisational affiliations of each member of the review team.

Miss Filipa Alves-Costa (University of Bath)

Dr Catherine Hamilton-Giachritsis (University of Bath)

Dr Sarah Halligan (University of Bath)

Miss Hope Christie (University of Bath)

Dr Mariëtte van Denderen (University of Groningen)

12 Funding sources/sponsors

Give details of the individuals, organizations, groups or other legal entities who take responsibility for initiating, managing, sponsoring and/or financing the review. Any unique identification numbers assigned to the review by the individuals or bodies listed should be included.

This PhD is co-funded by the University of Bath Graduate School and national charity Escaping Victimhood.

13 Conflicts of interest

List any conditions that could lead to actual or perceived undue influence on judgements concerning the main topic investigated in the review.

Are there any actual or potential conflicts of interest? Yes

This PhD is co-funded by the national charity, Escaping Victimhood, which aims to help individuals overcome grief as a result of murder or manslaughter across the United Kingdom (UK). However, the research team work independently to the Charity and maintain their academic and scientific rigor, following standardized ethical principles and are as objective as possible. The Charity also sees the need for the research to remain independent and able to report all outcomes, all of which (positive or negative) can help their programme develop.

15 Review question(s)

State the question(s) to be addressed / review objectives. Please complete a separate box for each question. What are the main psychological interventions provided for homicidally bereaved individuals?

What is the efficacy of psychological interventions for homicidally bereaved individuals? (e.g., symptomatology, indicators of well-being, coping mechanisms)

16 Searches

Give details of the sources to be searched, and any restrictions (e.g. language or publication period). The full search strategy is not required, but may be supplied as a link or attachment.

The search will use core electronic bibliographic databases: APA PsycNET (searches across PsycINFO, PsycEXTRA, PsycTESTS and PsycARTICLES), PubMed, The Cochrane Library (Cochrane Database of Systematic Review and Web of Science. Grey literature will be included (e.g., technical or research reports from government agencies and reports from scientific research groups). Only articles published in English will be reviewed. Studies published prior to May 2016 will be reviewed in the first instance, but

searches will be re-run before submission for publication and any further studies retrieved will be included

17 URL to search strategy

If you have one, give the link to your search strategy here. Alternatively you can e-mail this to PROSPERO and we will store and link to it.

I give permission for this file to be made publicly available

Yes

18 Condition or domain being studied

Give a short description of the disease, condition or healthcare domain being studied. This could include health and wellbeing outcomes.

Many people are bereaved through homicide (murder or manslaughter) each year, both in the UK and internationally, and psychological distress is a common outcome. As a group, homicidally bereaved individuals may have a unique set of mental needs. The current review examines the main interventions available to support these individuals, and the efficacy of those interventions.

19 Participants/population

Give summary criteria for the participants or populations being studied by the review. The preferred format includes details of both inclusion and exclusion criteria.

Inclusion criteria: Participants: 1. Bereaved through homicide (murder or manslaughter; terrorism acts included) 2. Family or other close relationships with the person who died (e.g., adoptive family, close friend) will be included 3. Must be over 18 years old at time of study Exclusion criteria: 1. Individuals under 18 years old 2. Individuals bereaved through other circumstances rather than homicide (e.g., suicide and 'natural causes')

20 Intervention(s), exposure(s)

Give full and clear descriptions of the nature of the interventions or the exposures to be reviewed

Any psychological intervention which has been delivered to individuals bereaved by murder/manslaughter will be included in the review. Psychological interventions can be delivered in a one-to-one or a group based format, with a variable number of sessions in a public and/or private context. Moreover, a broad range of potential psychological interventions are available, such as: Cognitive behaviour therapy (CBT), Interpersonal psychotherapy (IPT), Narrative therapy, Family therapy and family-based interventions, Mindfulness-based cognitive therapy (MBCT), Acceptance

and commitment therapy (ACT), Solution-focused brief therapy (SFBT), Dialectical behaviour therapy (DBT), Schema- focused therapy, Psychodynamic psychotherapy, Emotion-focused therapy, Hypnotherapy, Self-help and Psychoeducation. This review seeks to access studies conducted with individuals psychologically supported after an experience of homicidal bereavement and then determinate what modality of interventions are effective for these specific populations.

21 Comparator(s)/control

Where relevant, give details of the alternatives against which the main subject/topic of the review will be compared

(e.g. another intervention or a non-exposed control group).

Studies that include either an untreated murder-manslaughter bereaved control group, or a pre-post treatment comparison for a treated group will be included.

22 Types of study to be included initially

Give details of the study designs to be included in the review. If there are no restrictions on the types of study design eligible for inclusion, this should be stated.

Inclusion Criteria: 1. Longitudinal, Randomized control trials and case control studies will be included 2. Studies with validated measures assessing psychosocial and other functional outcomes, such as health, social and professional/career indicators, coping mechanisms 3. Qualitative studies will be included 4. Quantitative studies need to have validated measures to be included Studies with the following exclusion criteria will not be included: 1. No

specific mental, social health intervention and no outcomes or outputs 2. Qualitative studies not related with intervention and its effectiveness 3. No validated outcome measures are included 5. Absence of control group or post intervention comparison 6. Single case studies

23 Context

Give summary details of the setting and other relevant characteristics which help define the inclusion or exclusion criteria.

n/a

24 Primary outcome(s)

Give the most important outcomes.

The main outcome is to establish a set of psychological interventions that have been used effectively with individuals who have experienced bereavement through murder-manslaughter. Give information on timing and effect measures, as appropriate.

25 Secondary outcomes

List any additional outcomes that will be addressed. If there are no secondary outcomes enter None.

As a secondary outcome, information about the key targets of interventions (e.g., in the mental health domain) will be collated. In addiction it also seeks to improve knowledge about which type of interventions are more effective in specific domains (e.g., interventions in different time points, effectiveness according to individual, situational and contextual variables, etc.).

Give information on timing and effect measures, as appropriate.

26 Data extraction, (selection and coding)

Give the procedure for selecting studies for the review and extracting data, including the number of researchers involved and how discrepancies will be resolved. List the data to be extracted.

Tittles and/or abstracts of studies using the search strategy will be screened by one author (FAC) in order to decide if studies meet the inclusion criteria previously outlined. A second independent screen will be completed by collaborator HC. Any disagreements over the eligibility of particular studies will be resolved by discussion with co-authors

CHG/SH. A pre-piloted form will be used to extract data from the included studies. Extracted information will include: General information: Year the study was conducted and published Date of data extraction Record number (to uniquely identify study) Author Article title Citation Type of publication (e.g. journal article, conference abstract) Country of origin Source of funding Study characteristics: Aim/objectives of the study Study design Study inclusion and exclusion criteria Recruitment procedures used (e.g. details of randomisation, blinding) Number of participants Participant characteristics Demographic information Type of bereavement Intervention and setting Setting in which the intervention is delivered (rational, format, duration and frequency, context) Description of the intervention(s) and control(s) Description of co-interventions (if relevant) Outcome data/results Measurement tool or method used Unit of

assessment/analysis/Statistical techniques used Length of follow-up, number and/or times of follow-up measurements For all intervention group(s) and control group(s): Number of participants enrolled Number of participants included in analysis Number of withdrawals, exclusions, lost to follow-up Intention to treat analysis present/absent Additional information Record details of any additional relevant outcomes reported Costs Resource use Suggested mechanisms of action

27 Risk of bias (quality) assessment

State whether and how risk of bias will be assessed, how the quality of individual studies will be assessed, and whether and how this will influence the planned synthesis.

A standard Cochrane risk of bias toll and Hawker checklists will be used, as applicable. Results of these assessments will be reported alongside study characteristics.

28 Strategy for data synthesis

Give the planned general approach to be used, for example whether the data to be used will be aggregate or at the level of individual participants, and whether a quantitative or narrative (descriptive) synthesis is planned. Where appropriate a brief outline of analytic approach should be given.

A narrative synthesis of the findings will be provided, including: Studies Structure and details about the interventions

Participants and their characteristics Methodologies Outcomes of the interventions

29 Analysis of subgroups or subsets

Give any planned exploration of subgroups or subsets within the review. 'None planned' is a valid response if no subgroup analyses are planned.

None planned.

Review general information

30 Type of review

Select the type of review from the drop down list. Intervention

31 Language

Select the language(s) in which the review is being written and will be made available, from the drop down list. Use the control key to select more than one language.

Will a summary/abstract be made available in English? Yes

32 Country

Select the country in which the review is being carried out from the drop down list. For multi-national collaborations select all the countries involved. Use the control key to select more than one country.

England

33 Other registration details

Give the name of any organisation where the systematic review title or protocol is registered together with any unique identification number assigned. If extracted data will

be stored and made available through a repository such as the Systematic Review Data Repository (SRDR), details and a link should be included here.

34 Reference and/or URL for published protocol

Give the citation for the published protocol, if there is one. n/a

Give the link to the published protocol, if there is one. This may be to an external site or to a protocol deposited with

CRD in pdf format.

I give permission for this file to be made publicly available

Yes

35 Dissemination plans

Give brief details of plans for communicating essential messages from the review to the appropriate audiences. Do you intend to publish the review on completion?

Yes

37 Details of any existing review of the same topic by the same authors

Give details of earlier versions of the systematic review if an update of an existing review is being registered, including full bibliographic reference if possible.

n/a

38 Current review status

Review status should be updated when the review is completed and when it is published. Ongoing

39 Any additional information

Provide any further information the review team consider relevant to the registration of the review. n/a

40 Details of final report/publication(s) This field should be left empty until details of the completed review are available. Give the full citation for the final report or publication of the systematic review. Give the URL where available.

Appendix J: Biography and Research Dissemination

Filipa Alves-Costa has a Degree in Psychology and (Hons) Master's Degree in Justice/Forensic Psychology (University of Minho, Portugal, 2011). She has been working in a variety of fields in Psychology, both from research and intervention point of view (e.g., domestic and sexual abuse, clinical and forensic assessments, cognitive stimulation and adult resilience) in Portugal and in the UK. She is currently completing a funded PhD degree at the University of Bath (Department of Psychology, UK) looking at homicidal bereavement experiences together with a national charity (Escaping Victimhood). Filipa has also been teaching assistant since 2015 at the University of Bath.

National and international presentations

Alves-Costa, F. (2017). Listening to individuals on the post-homicide: a qualitative approach, paper presentation at ESTSS 2017 Conference | Copenhagen, Denmark.

Alves-Costa, F. (2017). Life goes on? Exploring the progression of homicidally bereaved individuals, paper at 3rd Annual Psychology PhD Conference, University of Bath, Bath, UK.

Alves-Costa, F. (2017). Everything changes: Listening to individuals following a homicidal bereavement experience, paper presentation at ImPACT Conference 2017 | Budapest, Hungry.

Alves-Costa, F. (2016). Homicidal bereavement listening to stories of survivors, paper presentation at CDAS-2016, University of Bath, Bath, UK.

Alves-Costa, F. (2016). Listening to individuals following a homicidal bereavement, poster presentation at Division of Forensic Psychology Annual Conference 2016 | BPS. Brighton, UK.

Alves-Costa, F. (2016). Homicidal bereavement in the UK: Listening to individuals bereaved through homicide, paper at 2nd Annual Psychology PhD Conference, University of Bath, Bath, UK.

Guest speaker

Alves-Costa, F. (2018). Homicidal bereavement: How do individuals perceive their post-loss experience? Seminar delivered for the Forensic and Clinical doctorate Psychology students at the University of Birmingham, Birmingham, United Kingdom.

Alves-Costa, F. (2017). Homicidal bereavement: what's known? Lecture delivered for the Health Psychology Masters students at the University of Bath, UK.

Alves-Costa, F. (2016). Homicidal bereavement: an overview (translated from Portuguese), Lecture delivered for the Forensic Psychology students at Lusófona University, Porto, Portugal.

Public engagement events

Alves-Costa, F. (2017). Who are the EV participants and how do they describe the EV intervention? Talk at the Escaping Victimhood Art & Photo Exhibition at the Old Bailey, London, UK.

Alves-Costa, F. (2016). Nice attack: how to help those who lose loved ones in traumatic acts of violence. Article written for the Conversation (http://theconversation.com/nice-attack-how-to-help-those-who-lose-loved-ones-in-traumatic-acts-of-violence-62561).